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ROYAL COMMISSION OF INQUIRY INTO CERTAIN
DEATHS AT THE HOSPITAL FOR SICK CHILDREN AND
RELATED MATTERS.

Hearing held
8th floor
180 Dundas Street West
Toronto, Ontario

The Honourable Mr. Justice S.G.M. Grange	Commissioner
P.S.A. Lamek, Q.C.	Counsel
E.A. Cronk	Associate Counsel
Thomas Millar	Administrator

Transcript of evidence
for

February 27, 1984

VOLUME 110

OFFICIAL COURT REPORTERS

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1 ROYAL COMMISSION OF INQUIRY INTO CERTAIN
2 DEATHS AT THE HOSPITAL FOR SICK CHILDREN
3 AND RELATED MATTERS.

4 Hearing held on the 8th Floor,
5 180 Dundas Street West, Toronto,
6 Ontario, on Monday, the 27th
7 day of February, 1984.

8 THE HONOURABLE MR. JUSTICE S.G.M. GRANGE - Commissioner
9 THOMAS MILLAR - Administrator
10 MURRAY R. ELLIOT - Registrar

11 APPEARANCES:

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13 T.C. MARSHALL, Q.C.) Counsel for the Attorney
14 D. HUNT) General and Solicitor General
15 L. CECCHETTO) of Ontario (Crown Attorneys
16) and Coroner's Office)
17 I.G. SCOTT, Q.C.) Counsel for The Hospital
18 I.J. ROLAND) for Sick Children
19 R. BATTY)
20 B. PERCIVAL, Q.C.) Counsel for The Metropolitan
21 D. YOUNG) Toronto Police
22 K. CHOWN Counsel for numerous Doctors
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25 B. SYMES) Counsel for the Registered
26 E. MCINTYRE) Nurses' Association of Ontario
27) and 35 Registered Nurses at
28) The Hospital for Sick Children
29 H. SOLOMON Counsel for The Ontario
30) Registered Nursing Assistants

(Cont'd)



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TORONTO, ONTARIO

(b)

APPEARANCES (CONTINUED)

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3		
4	E. FORSTER	Counsel for Phyllis Trayner - Nurse
5		
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7		
8	B. KNAZAN) B. JACKMAN)	Counsel for Mrs. M. Christie - R.N.A.
9		
10	S. LABOW	Counsel for Mr. & Mrs. Gosselin, Mr. & Mrs. Gionas, Mr. & Mrs. Inwood, Mr. & Mrs. Turner, Mr. & Mrs. Lutes, and Mr. & Mrs. Murphy (parents of deceased children)
11		
12	W.W. TOBIAS	Counsel for Mr. & Mrs. Hines (parents of deceased child Jordan Hines)
13		
14	J. SHINEHOFT	Counsel for Lorie Pacsai and Kevin Garnet (parents of deceased child Kevin Pacsai).

VOLUME 110



1 INDEX of WITNESSES

2	<u>Name</u>	<u>Page No.</u>
3		
4	<u>FRISE, Meredith (Resumed)</u>	4827
5	Cross-Examination by Ms. Symes	4827
	Cross-Examination by Mr. Labow	4867
6	Further Cross-Examination by Ms. Forster	4877
	Further Cross-Examination by Mr. Roland	4880
7	Re-Direct Examination by Ms. Cronk	4881
	Cross-Examination by Mr. Tobias	4888
8	<u>RADOJEWSKI, Elizabeth (Sworn)</u>	4916
9	Direct Examination by Ms. Cronk	4916
10		

11 INDEX of EXHIBITS

12	<u>No.</u>	<u>Description</u>	<u>Page No.</u>
13			
14	363	Curriculum Vitae re Elizabeth Radojewski	4921
15	364	Patient Incident Report re Paul Murphy, 19.08.80	4962
16	365	Patient Incident Report re Laurette Heyworth, 20.08.80	4967
17	366	Letter to the Commission from Dowling and Henderson, January 11th, 1984 with attachment	4970
18	367	Document entitled "Elizabeth Radojewski - (List of Relevant Children)".	4975
19			
20			
21			
22			
23			
24			
25			



EMT.jc

A 1

2

--- Upon commencing at 10:00 a.m.

3

MEREDITH FRISE, (Resumed)

4

THE COMMISSIONER: Yes, Miss Symes?

5

CROSS-EXAMINATION BY MS. SYMES:

6

Q. Miss Frise, my name is Beth Symes and I represent the Registered Nurses Association of Ontario and a number of individual nurses including Bertha Bell and Karen Power.

9

When you were hired as a Registered Nursing Assistant at The Hospital for Sick Children in March of 1980 I gather that was just prior to the move to Wards 4A/4B?

13

A. That is right.

14

Q. And I gather that this was your first job as a registered nursing assistant?

15

A. That's right.

16

Q. So you were brand new to this profession?

18

A. That's right.

19

Q. And you were brand new to The Hospital for Sick Children?

21

A. That is correct.

22

Q. And you were brand new to cardiology?

23

A. That's correct.

24

25



A.2

1

2

Q. And at the move you were then
assigned to 4B?

3

A. That's right.

4

Q. And did you ever work on 4A?

5

A. Once in a while you may work
on 4A as a relief person.

6

Q. You were I gather on Karen
Power's team?

7

A. That's right.

8

Q. You were never on Phyllis
Trayner's team?

9

A. No, I was not.

10

Q. And just so I understand, Karen
Power's team is not the team that is parallel to the
Trayner team?

11

A. That's right.

12

Q. In fact Karen Power's team was
parallel to Marie Mandal's team?

13

A. That's correct.

14

Q. So in other words the team
that you worked on, the Power team, would have followed
or been opposite to the Bell team?

15

A. That's right.

16

Q. In other words, when you were
coming off the Bell team might be coming on?

17

18



A.3

1

A. That's correct.

2

Q. Or vice versa.

3

A. That is right.

4

Q. And then as a member of Karen
Power's team you would have received report from
Bertha Bell's team?

5

A. That's right.

6

Q. You would not have received
report from Phyllis Trayner?

7

A. That's right.

8

Q. Or any member of her team?

9

A. That's right.

10

Q. Now when you were on the ward
it was the head nurse's job to evaluate the nurses?

11

A. Yes.

12

Q. On the ward?

13

A. That's correct.

14

Q. And I gather if you had seen a
nurse do anything wrong you would have reported it to
your head nurse?

15

A. That's correct.

16

Q. And I gather that at no time
during what we call the epidemic period did you ever
report Phyllis Trayner to your head nurse?

17

A. That's correct.

18

19

20

21

22

23

24

25



A.4

1

2

Q. Now I want to turn to March 23, 1981, and I gather that you attended at Phyllis Trayner's house prior to the meeting with Liz Radojewski at her house; is that right?

3

A. Yes, I did.

4

Q. And you identified on Thursday that Marie Mandal, Jane Partridge, Mary Jean Halpenny, yourself and Phyllis Trayner were present at that meeting?

5

A. That is right, yes.

6

Q. And I believe that you told us that Phyllis Trayner was the person who invited you?

7

A. Yes.

8

Q. And I believe you told us that Phyllis Trayner called you in the morning?

9

A. Yes.

10

Q. And that she asked you to come to her house to have a drink and something to eat?

11

A. That's right.

12

Q. And I believe you told us last day that you arrived at about 2 p.m.?

13

A. Yes.

14

Q. Now, was one of the reasons for the meeting or locating the meeting at Liz Radojewski's house that she had a new house?

15

16



A.5

1

2

THE COMMISSIONER: Sorry, is this the afternoon meeting or the night meeting?

4

MS. SYMES: The night meeting, sir.

5

THE COMMISSIONER: Yes. That is why I thought we were talking about the afternoon meeting.

6

MS. SYMES: I am trying to tie it in.

7

THE COMMISSIONER: Yes. All right.

8

Thank you.

9

MS. SYMES: Q. Was one of the reasons that the meeting scheduled for that evening was held at Liz Radojewski's because she had a new house?

12

A. Yes. Yes.

13

Q. And I gather you didn't know where that house was?

14

A. That's right.

15

Q. And many nurses didn't know where this house was?

17

A. That's right.

18

Q. But that Phyllis Trayner did know where it was?

20

A. Yes, she did.

21

Q. And I also gather that at that time Phyllis Trayner lived right near the Keele subway stop?

23

A. She lived near a subway stop. I

24

25



A.6

1

2 don't know whether it was Keele.

3

4

Q. Anyway, her place which was -
was very easy to get to?

5

A. Yes, it was.

6

7

8

Q. And that that was the reason

that a number of you agreed to meet at Phyllis Trayner's
house; that you knew where that was and then you could
go as a group to Liz Radojewski's?

9

A. Yes, that makes sense, yes.

10

11

Q. Now you said that Phyllis Trayner
had invited you. Is that correct?

12

A. That's correct.

13

14

Q. And I gather, though, you were
the person who invited Jane Partridge to attend?

15

A. I cannot recall whether I did
that. I could have. I don't recall at this point.

16

17

18

Q. Well, is it possible that you
called Jane Partridge and invited her to come to
Phyllis Trayner's?

19

20

A. It could be possible, but as I
said, I don't really recall whether I did or didn't.

21

22

23

24

Q. I have spoken to her, and she
informs me - I just want to check with you that this
is so - that in fact you called her in the late after-
noon of March 23rd to invite her to come to Phyllis
Trayner's?

25



A. 7

1

2

3

A. As I stated, I don't recall whether I phoned her at all.

4

Q. You don't recall?

5

A. No.

6

Q. And do you recall what time she would have arrived at this meeting?

7

A. No, I can't recall at this point when she arrived at the meeting.

9

Q. Is it possible it was close to 6 p.m.? That is, very late?

11

A. I don't really recall when she arrived there.

13

Q. In fact, Miss Frise, you had said yesterday that in answer to Mr. Lamek's question the meeting was about four hours long. Is it possible in fact that the meeting was very much shorter and that most people didn't arrive until about 6 p.m.?

17

A. No. From what I recollect I arrived there around two and we left at six.

19

Q. Okay. You arrived at about two but the other people could they have not come until six?

21

A. They could very well have. I don't really recall whether they came later or whether they came earlier.

24

25



A.8

1

2

Q. It has been called a meeting
but really it was a social event, wasn't it?

A. Yes, you could call it a social
event, yes.

Q. You had pizza and coffee before
you went to the meeting?

A. That is right.

Q. You said you are not sure or
you don't recall if you called Jane Partridge. Is it
possible that you were the person that invited other
people? Marie Mandal, for example?

A. I do recall phoning Marie Mandal
but I don't recall Jane Partridge.

Q. So you were the person that
invited Marie Mandal to come?

A. That's right.

Q. Were you the person that invited
Mary Jean Halpenny?

A. I don't recall.

Q. Might be?

A. Could be, but at this point I
don't recall.

Q. I gather that any discussion
that occurred would have occurred while you were
eating and having coffee?

24

25



A.9

1

A. That's right.

2

3

Q. I believe that you had told
Mr. Lamek that Liz Radojewski had told someone that
there was going to be a coroner's inquest into
Pacsai's death?

4

5

A. That's right, yes.

6

7

Q. And I gather you had never been
part of a coroner's inquest?

8

9

A. That's correct.

10

11

Q. Or investigation?

A. Right.

12

13

Q. And that you were nervous?

14

A. That's right.

15

Q. And I gather from what you told
Mr. Lamek that you also discussed that there had
been a number of deaths on the floor?

16

17

A. Yes, there were.

18

19

Q. That was not news to anyone?

20

A. No, it was not news.

21

22

Q. And that you also told Mr. Lamek
the third thing was that there was a concern that
maybe nurses were missing something; that is, not
picking up something with respect to the care of the
babies?

23

24

A. That's correct.

25



A.10

1

2 Q. And that wasn't new, was it?

3

A. No, it was not.

4

Q. That had been raised by the
5 nurses extensively?

6

A. Yes, it had.

7

Q. Over the period?

8

A. Yes.

9

Q. And that the deaths were
10 occurring on 4A and particularly on Phyllis Trayner's
team?

11

A. That's correct.

12

Q. And that wasn't you either?

13

A. No, it was not.

14

Q. The nurses all knew that?

15

A. Yes.

16

Q. And I gather then after you had
your pizza and coffee you went off to Liz Radojewski's.

17

A. Yes.

18

Q. And you arrived there about
7 o'clock?

19

A. Yes.

20

Q. Now at Liz Radojewski's I gather
21 that you had told Mr. Lamek one of the things in
22 discussion was that the nurses were looking for the
23 cause of deaths?

24

25



A.11

1

A. That's right.

2

Q. And that the nurses were upset?

3

A. That's correct.

4

Q. And I gather again, just as you
discussed at Phyllis Trayner's, that the nurses were
concerned that they weren't picking up things quickly
enough?

5

A. That's right.

6

Q. And that maybe a baby was
getting into trouble and they didn't notice it?

7

A. That's right.

8

Q. Again that was a theme that
had been repeated?

9

A. Yes.

10

Q. Not you?

11

A. No.

12

Q. I gather it also came up that
maybe a nurse had made a medication error?

13

A. Yes, it did come up.

14

Q. And so that is why there was
discussion about malpractice insurance?

15

A. Yes.

16

Q. And you have got that kind of
insurance through your professional association?

17

A. Yes.

18

19

20

-



B
DM/cr

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25

Q. Miss Frise, the topic of intentional harm to a baby, was that discussed at all at that meeting?

A. No, I can't recall anything like that being discussed.

Q. And that didn't even cross your mind at that meeting, did it?

A. No, it did not cross my mind at that meeting.

Q. Now, you have told Mr. Lamek, Mr. Hunt and Mr. Percival, that you had asked Mary Costello if the deaths had anything to do with digoxin?

A. Yes, I did.

Q. I gather you had worked the long days on Sunday?

A. Yes, I did.

Q. And that was the day when digoxin was locked up?

A. Yes.

Q. Team leaders could not carry the keys?

A. That's right.

Q. And supervisors were on the floor?



Frise, cr.ex.
(Symes)

1

2 A. That's right.

3

4 Q. And I guess while you were
working you must have wondered why?

5

6 A. That's correct.

7

8 Q. And I gather you got no
9 explanation whatsoever?

10

11 A. That's right.

12

13 Q. Do you remember if anyone
14 even offered any statement as to why this was
happening?

15

16 A. There was a bunch of them that
17 went down to the 4A parent room and they discussed
18 it. What was discussed in there, it was not passed
19 on to me. I was asked to stay on the floor while
20 they went in and talked to the supervisors.

21

22 Q. Did you ever hear the
23 phrase "It's for your own good"?

24

25 THE COMMISSIONER: We are talking
about as a nurse now.

19

20 Q. Yes.

21

22 A. Not that I can recall.

23

24 Q. But I gather from working
25 the long days on Sunday you had no idea as to why
these extraordinary measures were being taken?

26 A. That's right.

27

28



1

3

Q. And was one of your concerns
that there was something wrong with the drug digoxin
itself?

5

A. Yes.

6

Q. And was that discussed amongst
the other nurses?

8

A. Yes, it was.

9

Q. Maybe there was something wrong
with the strength of the concentration of digoxin?

10

A. That is correct.

11

Q. And is that why you asked that
question of Mary Costello that night?

13

A. Yes.

14

Q. And I gather she said she
couldn't comment, is that right?

15

A. That's right.

16

Q. Now this meeting that was
held at Liz Radojewski's that night, it is not an
unusual thing for nurses on your ward to meet to
discuss problems, was it?

20

A. No, it was not unusual at
that point, no.

21

Q. In fact that was the practice,
that if you had a problem you generally met to try
and straighten it out?

24

25



1

2 A. That's correct.

3

4 Q. And we have, for example, the
5 Ward meeting books from 4A and 4B, which are Exhibits
6 300 and 301, and they show a number of meetings over
7 the epidemic period?

8

9 A. Yes.

10

11 Q. And in fact this meeting at
12 Liz Radojewski's was not the first time that you
13 had met outside the Hospital?

14

15 A. No, it was not.

16

17 Q. We know that for example on
18 October 22nd they met at your house?

19

20 A. Yes, they did.

21

22 Q. And were you present when
23 the nurses met at Bertha Bell's?

24

25 A. No, I was not.

1

2 Q. But you know that it had
3 occurred on a prior occasion?

4

5 A. Yes.

6

7 Q. And in fact in the fall of
8 1980 certain nurses were saying, let's hold these
9 nurses' meetings outside the Hospital?

10

11 A. Yes.

12

13 Q. And the reasons for that were
14 very simple, it was quieter outside the Hospital?

15

16



1

5

A. Yes.

2

3 Q. You wouldn't get any
4 interruptions?

5

A. That's correct.

6

Q. And nurses would be more
7 relaxed?

8

A. That's correct.

9

Q. Now, at the meeting at your
10 apartment on October the 22nd, 1980, there is in
11 the notes a need for support meetings, do you recall
12 that?

13

A. Yes.

14

Q. And in answer to Mr. Lamek
15 on page 4716, you said that the support meetings
16 started soon after, you are not sure in how many
17 days, or a week?

18

A. No, I am not sure as to how
19 soon after it happened.

20

Q. On October 22nd, 1980, that
21 was after the death of a particular baby, you
22 recall then that there was a discussion of a need
23 for support?

24

A. Yes.

25

Q. And was there discussion also
of the need for perhaps you could have a psychiatrist



1
2 as was available to the Intensive Care Unit Nurses?

3 A. Yes.

4 Q. And the other possibility is
5 perhaps the Mental Health Nurse Andrea Frewin could
6 get involved?

7 A. Yes.

8 Q. Now, Ms. Frise, to the best
9 of your recollection when is the first time that
the nurses met with a psychiatrist?

10 A. We used to always meet with
11 him on a Friday, okay. I don't know what the day
12 of October 22nd was, but from my best recollection
13 I think it was the following Friday that that
particular group met with him.

14 Q. There has been other people
15 that have said they didn't meet with the psychiatrist
16 until after Susan Nelles was arrested. Is it
17 possible that you are mistaken and that the support
18 meeting with the psychiatrist didn't occur until
19 March of 1981?

20 A. I'm not sure about that.

21 Q. Do you ever recall meeting
with Andrea Frewin?

22 A. No, I don't recall meeting
23 with her.



1

2 THE COMMISSIONER: I am sorry, who
3 is Andrea Frewin?

4 MISS SYMES: Andrea Frewin is the
5 Staff Mental Health Nurse.

6 THE COMMISSIONER: You never met with
7 her at all?

8 THE WITNESS: No.

9 MISS SYMES: Q. So is it possible
10 in fact that the support meetings didn't occur
until after Susan Nelles was arrested?

11 A. When you say support meetings,
12 you mean support meetings with the psychiatrist?

13 Q. Yes.

14 A. Like I said I am not really
15 sure as to whether we started them before or after
with the psychiatrist.

16 Q. Now after Susan Nelles was
17 arrested, did you attend at these meetings with
18 the other nurses and the psychiatrist?

19 A. Yes, I did attend them.

20 Q. And I gather that the fact
21 that these meetings were held was well known to
everyone?

22 A. Yes, it was.

23 Q. At some time did you become

24

25



1

8 2 aware of the police attitude towards those meetings?

3 A. Yes, I did.

4 Q. How did you become aware of
5 it?

6 A. I became aware of it through
7 Bertha Bell.

8 Q. And what did you understand
9 was their attitude?

10 A. Their attitude that they were
11 frustrated.

12 THE COMMISSIONER: Who were frustrated?

13 MISS SYMES: Q. The police, what
14 was the police's attitude?

15 A. Towards the meetings?

16 Q. With the psychiatrist.

17 A. Okay, sorry. They were not
18 too pleased about these meetings.

19 Q. Do you know why?

20 A. From what I recollect is
21 that they thought we were all gathering together
22 to put our evidence all together so everyone would
23 tell the same story, which was not occurring at all.

24 Q. Now you have told Mr. Lamek
25 that on June 17th, 1981, Constable Murray came to
your parents' home in Peterborough to see you?



1

2 A. That's correct.

3

4 Q. And I gather he asked you if
5 you knew anyone who was possibly holding back
6 evidence?

7

8 A. That's right.

9

10 Q. And I gather that you answered
11 Bertha Bell and Karen Power?

12

13 A. That's correct.

14

15 Q. And on Thursday you told
16 Mr. Lamek that you had no information that either
17 Bertha Bell or Karen Power were holding back
18 information from the police?

19

20 A. That's right.

21

22 Q. And that is at page 4707 of
23 the transcript. I also believe you told him that
24 the only basis for that statement on June 17th
25 was that Bertha Bell and Karen Power had met as
friends with Susan Nelles after she was released
on bail?

19

20 A. Yes.

21

22 Q. I believe you said that Bertha
23 Bell and Susan Nelles were friends?

24

25 A. Yes.

22

23 Q. Are friends?

24

25 A. Are friends, yes.

24

25



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Q. And that Karen Power and Susan Nelles were friendly as well?

A. Yes.

Q. In April of 1981 when this happened, did you think that it was wrong for nurses who had been on Wards 4A/4B to meet socially with Susan Nelles?

A. Did I think it was wrong? I can't say that I thought it was wrong, I can't say that I thought it was right.

Q. Were you uncomfortable with it?

A. Yes.

Q. Now you obviously were not present at that social gathering?

A. That's right.

Q. But I gather after the nurses learned that it had occurred that Bertha Bell and Karen Power were quizzed by the nurses as to what had gone on?

A. Yes.

Q. They were quizzed at length?

A. Yes.

Q. And you knew that?

A. Yes.



1

2
11 Q. And they had told you, didn't
3 they, that Susan Nelles had talked about --

4

5 THE COMMISSIONER: I am sorry, who
6 are they?

7

8 MISS SYMES: They, Bertha Bell and
9 Karen Power.

10

11 THE COMMISSIONER: Yes, all right.

12

13 MISS SYMES: Q. Bertha Bell and
14 Karen Power had told the nurses that Susan Nelles
15 had talked about how horrible it was to be in jail?

16

A. Yes.

17

18 Q. And that Susan Nelles talked
19 about quilting?

20

A. Yes.

21

22 Q. So after the nurses had
23 uizzed Bertha Bell and Karen Power you knew what
24 the content of that social gathering was?

25

A. That's right.

5



BmB.jc
C 1

2 Q. And everybody, that is, Bertha
3 Bell and Karen Power assured everyone that nothing
4 had been asked and nothing had been said about the
5 deaths of the children?

6 A. That's right.

7 Q. So, you knew that?

8 A. Yes.

9 Q. Were you a little upset that
10 you hadn't been invited to that social gathering?

11 A. No, I was not upset.

12 Q. Well, why did you think it
13 stood out?

14 A. Why did what stand out, the
15 meeting?

16 Q. The fact that Bertha Bell and
17 Karen Power would meet socially with Susan Nelles?

18 A. In the fact that I guess only
19 individual people were invited to come to the place
20 and visit with her.

21 Q. And did you wish to be included?

22 A. No, I did not.

23 Q. Now, on June 17th, 1982 when
24 Constable Murray came to Peterborough and asked you
25 if you knew anyone who was possibly holding back
evidence, and you answered, did he ask you the basis
of your opinion?



C.2

1

2 A. No, he did not.

3

Q. Did you volunteer that basis?

4

A. Not that I can recall, no.

5

THE COMMISSIONER: I'm sorry, I find
that hard to understand. You mean to say that somebody
was holding back evidence and the policeman didn't
ask you what evidence was being held back and what
you meant by it?

9

10

THE WITNESS: As I stated, I can't
recall.

11

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THE COMMISSIONER: Well, there is quite
a difference between you can't recall and saying you
didn't say that. But it seems to me a pretty strange
way for a policeman to behave if you said that and
he didn't follow it up. But it may have been, it may
have been, I'm not saying that. If you remember that
he didn't, that's one thing, but if you just don't
remember whether he did or not that perhaps is another.

THE WITNESS: I can say I don't
remember if I did answer, like, say that I had a basis,
I presume that he would have wrote it down on the
statement.

THE COMMISSIONER: No, that isn't the
question. The question Miss Symes put to you, did he
ask you what the basis was for your saying that Bertha
Bell --



C.3

1

2 THE WITNESS: No.

3

4 THE COMMISSIONER: -- was withholding
something?

5

6 THE WITNESS: No.

7

8 THE COMMISSIONER: And the answer is
9 he didn't?

10

11 THE WITNESS: He didn't.

12

13 MS. SYMES: Q. He didn't ask you the
14 basis?

15

16 A. No, he did not.

17

18 Q. And the second question is, did
19 you tell him the basis, did you volunteer it?

20

21 A. No, I did not.

22

23 Q. When you were cross-examined by
24 Mr. Hunt at pages 4756 through 4758 yesterday, you
25 were asked:

26

27 Is there anything in Miss Bell's
28 attitude that you can recall that
29 would have raised that type of
30 question, that type of question in
31 your mind?

32

33 And you answered that --

34

35 MR. HUNT: What type of question is
36 that, just so the question is clear?

37

38 MS. SYMES: That type, in a rather

39

40



C.4

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2 long question starting on page 4755, Mr. Hunt asked
3 you:

4 "Now you told my friend Mr. Lamek
5 this morning in June of 1982, you told
6 Constable Murray from the Metropolitan
7 Toronto Police that you -- in response
8 to a question from him as to whether
9 or not you thought there was anyone
10 possibly withholding information, you
11 gave the names Bertha Bell and Karen
Power.

12 "A. That is right.

13 "Q. And you have explained as well
14 to my friend Mr. Lamek and to the
15 Commissioner in some questions asked
16 by him, what the basis for that was.
17 It involved the fact that you had
18 been informed of a meeting that had
19 taken place that apparently met with
the disapproval of the police.

20 "Now, I think we can all appreciate
21 that sometimes people have feelings
22 that are difficult to put a finger on.

23 "A. That is right.

24 "Q. I want to ask you, is there or
25



C.5

1

2

"was there at that time anything else
about Bertha Bell that led you to
feel that possibly she was withholding
some information from the police?

3

"A. Nothing that I can recall, no.

4

"Q. Is there anything as you cast
back through your memory that Bertha
Bell said to you at any time that
would have given you some reason to
wonder in your own mind whether she
was telling everything that she knew?

5

"A. Not that I can recall, no."

6

And then the question:

7

"Q. Is there anything in her
attitude that you can recall that
would have raised that type of
question in your mind?"

8

It's not absolutely clear as to what
that was. But you had answered that question that
Ms. Bell was not pleased that the police would come
and talk to her all the time?

9

A. That's right.

10

MR. HUNT: I don't see that answer.

11

My friend has read now a page and a half of the
build-up to this and then stopped at the precise

12

13



C.6

1

2 point that makes it clear to the witness what she
3 said last week.

4 THE COMMISSIONER: Yes.

5 MS. SYMES: The question was:

6 "Q. What was that?

7 "A. In her attitude in that she
8 would state that the police would
9 come -- the police would come and
10 talk to her all the time; were always
11 bugging her. That didn't please her
12 at all. She wasn't pleased with that."
13 That is exactly it, I have summed up
14 the answer.

15 MR. HUNT: Well, there is no need for
16 a summary, Mr. Commissioner. We have a transcript
17 for the answer. My friend obviously places great
18 importance on this. She has led the build-up to it
19 and if she intends to pursue it, I suggest the
witness be informed accurately as to what exactly it
was she said.

20 MS. SYMES: Q. Do you recall giving
21 the answer?

22 A. Could I read the transcript,
23 please?

24 Q. Sure.

25



C.7

1

2 MS. SYMES: Could she please be given
3 the transcript at 4757, please.

4 THE COMMISSIONER: Miss Solomon to the
5 rescue. We don't have an extra copy.

6 MS. SYMES: Q. Do you have that?

7 A. Yes.

8 Q. Do you recall giving those
answers?

9 A. Yes.

10 Q. Could you just leave the
11 transcript, please, I would just like to read on.

12 MS. SOLOMON: Yes.

13 MS. SYMES: Q. "Q. Is it fair to say
14 that then you perceived in her attitude
15 a rather negative response to the
16 police efforts to ask her questions?

17 "A. That is correct, yes.

18 "Q. Was she rather vocal in that
particular response that she had?

19 "A. What do you mean 'vocal'?

20 "Q. By vocal I mean did you hear her
say it more than once?

21 "A. I think maybe I heard her say it
22 twice."

23 THE COMMISSIONER: What is the question

24

25



C.8

1

2 that you are asking?

3 MS. SYMES: I haven't come to the
4 question, I'm just reading the transcript.

5 THE COMMISSIONER: Oh, all right.

6 MS. SYMES: Q. When you had given
7 this information, this opinion to Constable Murray
8 on June 17th, 1982, were you aware that Ms. Bell
9 had been interviewed three times by the police at
10 The Hospital for Sick Children after Susan Nelles
had been arrested and before the preliminary?

11 A. Yes, I knew that, yes.

12 Q. And you were aware that Ms. Bell
had made no complaints about those three interviews?

13 A. That they had came once within
14 that period, if I'm correct, to the Hospital and
15 wanted to question her but she stated that she
16 couldn't go down because the floor was uncovered
17 and they weren't too pleased that she wouldn't come
down.

18 Q. The three interviews occurred
19 on March 26th, 1981, April 24th, 1981 and May 20th,
20 1981?

21 A. Yes.

22 Q. Shortly after the arrest of
23 Susan Nelles. Do you recall with respect to those
24

25



C.9

1

2 three interviews if Ms. Bell had any complaints, those
3 three particular ones?

4 A. No, I can't recall.

5 Q. In fact, the complaints from
6 Bell occurred after the preliminary, didn't they;
7 after the preliminary was over?

8 A. Yes, I believe so, yes.

9 Q. And one of those was as a result
10 of again after the preliminary the police came to
11 her home on very short notice?

12 A. That's right.

13 Q. And Ms. Bell was upset that the
14 police had come to her home because she had small
15 children then?

16 A. That's correct.

17 Q. And that she wasn't unique, was
18 she, that there were other nurses who didn't like the
19 police coming to their home?

20 A. Yes.

21 Q. And that she had complained that
22 the police had come to her home?

23 A. Yes, she did.

24 Q. And that was on one of the
25 occasions that you heard her voice a complaint?

A. Yes.



C.10

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2

Q. Now, the second one, did Ms. Bell
tell you that the police had arrived on the ward and
that there had been some mix-up about scheduling her
interview?

3

4

A. I believe that is correct, yes.

5

6

Q. And that she felt, Ms. Bell
felt that she was unable to leave the floor because it
was busy and she thought she was needed?

7

8

A. That's right.

9

10

Q. And did she also tell you that
the police didn't understand that and that they had
somehow threatened to report her to the Director of
Nursing?

11

12

A. I don't recall that part.

13

14

15

16

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22

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EMT/cr

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2 Q. But you understood there
3 was some misunderstanding or a disagreement as
4 to whether or not Miss Bell could leave the floor
5 at that time?

6

A. Yes.

7

Q. And go and speak to the police?

8

A. That's right.

9

Q. And she was a bit upset about
that?

10

A. That's right.

11

Q. And is it fair to say if you
12 were in her shoes you would have been upset as well?

13

A. Yes.

14

Q. Because as a nurse is your
15 first priority to your patients that you are
assigned?

16

A. That's right.

17

Q. So, Miss Frise, is it fair
18 in sum that you have absolutely no basis in fact
then for your statement that either Bertha Bell
19 or Karen Power withheld evidence from the police?

20

A. That's right. That is what
I stated before.

22

MR. HUNT: Well, Mr. Commissioner,
23 my friend stopped and I was waiting to see whether

24

25



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2 at some point she was going to go on refreshing
3 this witness' memory as to her answer the other
4 day. She stopped about a page before it ended
5 where the witness gives her evidence that she
6 detected in what she heard from Bertha Bell, and
7 I am looking at 4758, that she had - she agreed
8 that one could describe the attitude that she per-
9 ceived in Bertha Bell as one that did not sound like
a very co-operative one.

10

11 Without refreshing the witness'
12 memory as to that, and I don't know why my friend
13 chose not to do that, she then asks is there no
14 basis at all, and it is my submission the witness
15 has given in her evidence last week the basis for
feeling that she didn't feel this woman had a very
co-operative attitude.

16

MISS SYMES: Well ---

17

18 THE COMMISSIONER: Let's just carry
on, Miss Symes.

19

MISS SYMES: Q. Miss Frise ---

20

21 THE COMMISSIONER: I am sorry to say
that I would much rather hear from Miss Bell, as we
have, than hear from Miss Frise on this subject.
22 However, you go ahead.

23

MISS SYMES: Well, Mr. Commissioner,

24

25



1

3 2 it is very important to my clients that ---

3

4 important to your clients, but I don't know how it
5 really helps us on the cause of death or the police
6 investigation, but perhaps it does.

7

MISS SYMES: Well, Mr. Commissioner,
yesterday she gave - last day she gave opinions
that I submit were ill-founded.

9

THE COMMISSIONER: Yes, all right.

10

11

MISS SYMES: And my clients are
very upset about it and have a reputation in the
community.

12

13

14

15

16

THE COMMISSIONER: Well, yes, but
I am not dealing with the reputation of a community.
You understand that. I am not dealing with that.
I am dealing with the cause of death of some 36
children - babies.

17

MISS SYMES: Yes.

18

19

20

21

22

23

THE COMMISSIONER: And also with
the police investigation. But I don't want this
police investigation to turn into some kind of
vendetta between the police and the nurses. The
problem is whether the police investigated the
matter properly. Isn't that the issue that is going
to be before me.

24

25



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4 2 MISS SYMES: Mr. Commissioner,
3 the police and the Attorney-General have clearly
4 put in issue before you as to whether or not the
5 nurses co-operated.

6

7 THE COMMISSIONER: Yes. All right.
I started this off by saying I would rather hear
from Miss Bell ---

8

MISS SYMES: Yes.

9

10 THE COMMISSIONER: - than I would
11 from Miss Frise as to what was going on in Miss
12 Bell's mind, and we have heard that. However, I
13 am obviously not impressing this, so carry on.

14

MISS SYMES: Q. Miss Frise, last
15 day you were asked the question on page 4758 about
16 Miss Bell:

17

"Certainly it didn't sound like a
18 very co-operative one, I guess.

19

A. I guess you can say that."

20

THE COMMISSIONER: Sorry, what page
21 was that?

22

MISS SYMES: 4758, sir.

23

THE COMMISSIONER: Oh, yes. All
24 right.

25

MISS SYMES: Q. Miss Frise, do you
have anything, any basis for the statement that Miss



1

5 2 Bell was not co-operative in sharing information
3 with the police?

4 A. No.

5 Q. On page 4760 you were asked
6 as to whether or not you had agreed with the
7 assessment of the cardiologists as to the cause
8 of death of the children, and you had told the
9 Commission that there was a child who had died and
10 that you did not explain - you did not, pardon me -
11 accept the explanation given by the cardiologist,
12 and this was a child who had had surgery, whose
13 AP window had closed.

14 Do you recall talking about this
15 child?

16 A. Yes.

17 Q. First of all, what is an AP
18 window?

19 A. It is a shunt.

20 Q. A shunt? So this is a child
21 whose cause of death was put down to that the shunt
22 occluded or closed?

23 A. Yes.

24 Q. And you said that this child
25 died on 4B?

26 A. Yes.



1

2 Q. And that this child was in
3 Room 439?

4 A. That is correct.

5 Q. And that this child died at
6 night?

7 A. Yes.

8 Q. Were you on for the death?

9 A. No, I was not.

10 Q. You were not?

11 A. No.

12 Q. I have tried to go through
13 each of the children that died on 4B and I couldn't
14 determine which one you were on.

15 A. I can't remember what the
16 child's name was.

17 Q. Okay. I am also unable to
18 determine any child that died in Room 439.

19 A. The child died there.

20 Q. You weren't there, though,
21 at the time of death?

22 A. I came on in the morning.

23 Q. And you can't recall when that
24 happened? In the epidemic period, from July until
25 March can you recall when?

THE COMMISSIONER: If it were a child



1

2 that died either in the ICU or in the operating
3 room we wouldn't be investigating the child, that's
4 all.

5

MISS SYMES: Yes, sir.

6

Q. Miss Frise, I gathered from
what you said that the child died on 4B?

7

A. That's right.

8

Q. And if I were to read you
the names of the children who died on 4B, might that
be of assistance to you?

9

A. It may be, yes.

10

11

Q. Laura Woodcock, who died the
30th of June.

12

A. No.

13

14

Q. Taylor who died the 27th of
July. Onofre who died the 9th of December.

15

A. Keep going.

16

Q. Could you say yes or no so
the reporter can put it down.

17

Belanger who died the 28th of
December.

18

A. No.

19

Q. Bruce Floryn who died the
7th of February.

20

A. No.

21

22

23

24

25



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2

Q. Jordan Hines who died the 8th
of March.

4

A. No.

5

Q. Manojlovich who died the 12th
of March.

6

A. No.

7

Q. Kevin Pacsai who died the
12th of March.

9

A. No.

10

Q. Kristin Inwood who died the
13th of March.

11

A. No.

12

Q. I cannot find any other child
that died on 4B.

13

A. I am sorry ---

14

Q. You can't help me?

15

A. I can't help you. If I know
who worked that night, if we looked into the
assignment book maybe you could find it.

16

Q. It is hard to do that without
a date.

17

A. I don't recall as to what
period it is, I am sorry.

18

MISS SYMES: Thank you very much.

19

Those are my questions.

20

21

22

23

24

25



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2 THE COMMISSIONER: All right. Thank
3 you.

4 I think we covered the second row.

5 Mr. Knazan?

6 MR. KNAZAN: I have no questions.

7 THE COMMISSIONER: You will come
later.

8 Mr. Olah?

9 MR. OLAH: No questions, Mr.
10 Commissioner.

11 THE COMMISSIONER: Mr. Labow?

12 MR. LABOW: Thank you, Mr.
13 Commissioner.

14 CROSS-EXAMINATION BY MR. LABOW:

15 Q. Good morning, Miss Frise.
16 My name is Stephen Labow. We represent the parents
17 of six of the children, including Kristin Inwood and
18 Barbara Gionas.

19 Now, the win sheets indicate that
20 you were on Ward 4B the night that Barbara Gionas
21 arrested. Do you have any recollection about that
22 arrest?

23 A. No, I do not.

24 Q. You were also on on the 11th
25 and 12th of March taking care of Kristin Inwood?



1

2 A. That's right.

3

4 MR. LABOW: Could the witness see
the progress notes for Kristin Inwood, please?

5

6 Q. Kristin Inwood was admitted
on the 11th of March and you were on long days?

7

8 A. Right.

9

10 Q. And when you see the progress
notes, the first progress note is yours.

11

12 It is on page 61, Mr. Commissioner.

13

14 THE COMMISSIONER: Page 61?

15

16 MR. LABOW: 61.

17

18 Q. Now do you know if you admitted
Kristin Inwood to the ward?

19

20 A. Yes, I did.

21

22 Q. Do you have any idea what time
that was?

23

24 A. It was in the afternoon, I
can't give the exact time.

25

26 Q. What did her condition appear
to be like to you?

27

28 A. It appeared to be that she
was in cardiac failure.

29

30 Q. Was she in very bad shape
upon her admission?

31

32 A. She was in bad enough shape

33

34

35



1

2 and bad enough failure that she couldn't feed as is
3 stated in this.

4

Q. Now do you know - you are not
5 qualified as I understand it to give digoxin?

6

A. That's right.

7

Q. If digoxin is ordered?

8

A. That's correct.

9

Q. Do you know which of the other
nurses was supposed to be giving medications for
you that day?

10

A. I can't recall who was giving
my medications that day, no.

11

12

Q. When Kristin Inwood was
admitted were you given any special instructions
regarding her that you can recall?

13

A. No.

14

Q. We have heard that although
digoxin was ordered digoxin was ordered held because
her electrocardiogram showed signs of digoxin
toxicity upon her admission.

15

Did you ever hear that or hear of
that?

16

A. No.

17

Q. Do you know if she was given
any digoxin on the 11th of March?

18

19



1

2 A. I remember that there was a
3 crisis that this child received digoxin that was
4 not to receive digoxin.

4

5 Q. That was the next day?

5

6 A. I can't recall as to that
7 day as to whether she did receive digoxin.

7

8 Q. Now the next day, and turn
9 to page 62, your note is also there. You once more
10 took care of Kristin Inwood on the 12th long day
shift?

10

11 A. Yes.

11

12 Q. Is that correct?

12

13 A. Yes.

13

14 Q. Did you hear when you came
15 in that morning that she had been given a mistaken
16 dose of digoxin earlier?

16

17 A. I believe I did, yes.

17

18 Q. Were you given any special
19 instructions regarding that?

19

20 A. No I was not.

20

21 Q. Did you know that digoxin
22 had been placed on hold early that morning?

21

22 A. I can't say that I knew that,
23 no.

23

24 Q. As a registered nursing

24

25



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2 assistant in charge of this child would you normally
3 know if that was the case?

4 A. Yes, because you do look at
5 the Cardexes and the medications that the child
6 is on.

7 Q. During the day that you were
8 there, aside from the fact that she wouldn't drink
9 from the bottle, how did she appear on the 12th of
March?

10 A. At times she appeared
11 distressed.

12 Q. Could you turn to the page
13 before, page 61? There is a note by Ms. Lyons.

14 A. Yes.

15 Q. Just under your note. And
16 at the very bottom of her note it says "Condition
17 in no apparent distress". Was that not your impression
of this child?

18 A. That's not my impression. .
19 Just reading by the vital signs this child was in
20 distress. -

21 Q. The vital signs noted by Miss
Lyons?

22 A. That is right.

23 Q. Why do you say that?

24

25



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2 A. Well, she had a respiratory rate
3 of 60 to 100.

4 Q. And what should her
5 respiratory rate be?

6 A. Her respiration should be -
7 it shouldn't be up as high as 100. It should be
8 down into the 50s.

9 Q. Do you have any idea why
10 with those signs a nurse would write in no apparent
11 distress?

12 A. No, I have no idea why
13 she would write that.

14 THE COMMISSIONER: Whose signature
15 is that, do you know?

16 THE WITNESS: Yvonne Lyons.

17 MR. LABOW: Lyons, Mr. Commissioner,
18 L-y-o-n-s.

19 Q. In your note on the 12th, on
20 page 62, does it say - can you tell me what it says
21 for respiration?

22 A. It says respirations 98 to 58.

23 Q. Now that would mean to you that
24 the child was in some kind of distress?

25 A. At a point in time through
the day, yes.



1

2 Q. And did you note that anywhere?

3 A. I didn't note it that she was
4 in distress, but by noting that her respirations
5 were high you can go by that.

6 Q. Do you recall telling anyone
7 that this child was in distress?

8 A. If her respirations were up
9 that high I probably would have told someone through
10 the day.

11 Q. Who would you normally have
12 told?

13 A. I would have told the girl
14 that was in charge, the team leader.

15 Q. But you don't recall
16 specifically?

17 A. As to whether I ---

18 Q. As to whether you did or did
19 not on that day?

20 A. I don't recall.

21 Q. Did you think that Kristin
22 Inwood was at imminent risk of death?

23 A. No, I did not.

24 Q. Were you surprised when she
25 died?

26 A. Yes, I was.



1

2 Q. Was it ever - did you ever
3 bring it up to anyone, ask them why she had died?

4 A. No, not that I can remember.

5

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2 Q. Miss Frise, I would just like
3 to ask you about one other thing.

4 Mr. Registrar, this is Exhibit 301.

5 At page 9 of Exhibit 301.

6 A. Yes.

7 Q. The second page of the note
8 from a meeting on October 23rd that was apparently
9 in your apartment; is that correct?

10 A. Yes.

11 Q. Now, at the very top of page
12 9 there is a note concerning doctors. Could you
13 tell me what the note says, please.

14 I'm sorry, Miss Cronk is going to
15 give you the original document, and it will be a lot
16 easier to read.

17 A. Okay. Thank you.

18 We were feeling that, as nurses, we
19 were feeling that doctors were not passing on the
20 messages as to how sick these children were and how
21 close we should observe them, and then it follows to
22 say that the Fellows, we were feeling that some of
23 the Fellows and the Residents were not, did not seem
24 to have enough experience in the cardiology field to
25 warn us beforehand as to how sick the children were.

Q. Did you bring this problem
up to anyone?



1

E2 2 A. This problem here? This
3 problem was discussed at this meeting.

4

team leader?

5

A. It was discussed with whoever
6 was at this meeting.

7

Q. Well, Karen Power was at the
8 meeting.

9

A. Yes, she was. Yes.

10

Q. Now, the last sentence of
11 that top note, can you tell me what it says please.
Just read it out.

12

A. "Dr. Freedom blaming the
13 doctors on account of they don't order
14 the right meds."

15

Q. So that the word there is
16 "blaming"?

17

A. "Blaming", yes.

18

MR. LABOW: Thank you. I have no
19 further questions.

20

THE COMMISSIONER: Thank you, Mr.
Labow.

21

Mr. Shinehoft?

22

MR. SHINEHOFT: I have no questions,
23 Mr. Commissioner.

24

25



1
2 THE COMMISSIONER: Am I missing
3 someone? I don't see anyone else around.

4 MR. LABOW: Mr. Shanahan told me if
5 he wasn't here he had no questions.

6 THE COMMISSIONER: I hope he has lots
7 of questions in Provincial Court.

8 Miss Solomon?

9 MS. SOLOMON: Mr. Tobias is not here.
He did mention to me he had questions.

10 THE COMMISSIONER: Oh, yes, Miss
11 Forster?

12 MS. FORSTER: Mr. Commissioner, before
13 Miss Solomon proceeds, I wonder if I might ask a
14 few questions arising out of the evidence on Thursday
15 afternoon?

16 THE COMMISSIONER: Arising out of the
17 evidence Thursday afternoon, yes.

18 FURTHER CROSS-EXAMINATION BY MS. FORSTER:

19 Q. Mr. Frise, you told Mr.
20 Percival on Thursday afternoon that shortly after
21 Susan Nelles was arrested you had lunch with Mrs.
22 Trayner at the Eaton Centre.

23 A. That's correct.

24 Q. And do you recall how soon
25 after Miss Nelles' arrest that lunch took place?



E4

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3

A. No, I can't recall as to how

4

soon after.

5

Q. Well, we heard evidence that
the Trayner team was off duty for a while. Was it
after Mrs. Trayner came back to work?

6

A. I am not sure.

7

Q. I understand that Lynn
Johnstone was also present at that lunch, is that
correct?

10

A. That is right.

11

Q. And during the course of the
lunch the three of you discussed Susan Nelles' arrest?

12

A. Yes.

13

Q. And did you also discuss the
fact that the police suspected that the four babies
had died from an overdose of digoxin?

16

A. Yes.

17

Q. And I suggest that during the
course of the lunch you also discussed where someone
might find digoxin if they wanted to murder babies
with it; is that right?

20

A. Yes.

21

Q. Do you recall Mrs. Trayner
mentioning that when she had been questioned by the
police they asked her that question, where someone

24

25



1
E5 2 might get digoxin?

3 A. I can't recall her stating
4 that.

5 Q. You do recall however the
6 three of you discussed how one might get digoxin
7 if they were going to deliberately cause harm to
babies?

8 A. Yes.

9 Q. And I take it that during
10 the course of the lunch the point came up as to whether
11 you could buy digoxin in the drugstore?

12 A. Yes.

13 Q. And in particular whether
14 you could buy it over the counter, or whether you needed
a prescription?

15 A. That's right.

16 Q. And you didn't know the
17 answer to that, I take it?

18 A. That's correct.

19 Q. And neither did Phyllis
20 Trayner?

21 A. That's correct.

22 Q. You were curious to find out
23 how easy it was to buy digoxin?

24 A. Yes.

25



E6

1 Q. And so was Mrs. Trayner?

2 A. Yes.

3 Q. And is that the reason that
4 the two of you went to a drugstore, just to see how
5 easy it was to obtain digoxin?

6 A. Yes, that makes sense. Yes.

7 Q. And that was in the context
8 of this investigation into the deaths at Sick Kids?

9 A. Yes.

10 Q. And at the time you went to
11 the drugstore, I take it the deaths on 4A and 4B
12 had stopped, had they? You went after the epidemic
13 period?

14 A. Yes.

15 MS. FORSTER: Thank you. Those are
16 all my questions.

17 MR. ROLAND: Sir, I have a couple
18 of questions arising out of the last question or so
19 asked of this witness by Mr. Labow about the note on
page 9 of Exhibit 301.

20 THE COMMISSIONER: Yes.

21 MR. ROLAND: Which he asked the witness
22 to read. If I might --

23 THE COMMISSIONER: Yes. All right.

24 FURTHER CROSS- EXAMINATION BY MR. ROLAND:

25 Q. Miss Frise, I take it Dr.



1
2 E7 Freedom was not at the meeting himself?

3 A. That is right.

4 Q. And someone had said --
5 therefore, I gather someone at the meeting said
6 something about Dr. Freedom?

7 A. Yes.

8 Q. Do you remember who that was?

9 A. No, I cannot remember.

10 Q. I gather it wasn't you,
11 although you recorded this? It was somebody else
speaking --

12 A. That's right.

13 Q. -- when you recorded this?

14 A. Yes.

15 Q. And you have no idea who
16 said that?

17 A. No, I can't recall who said
it, I'm sorry.

18 MR. ROLAND: Thank you.

19 THE COMMISSIONER: Yes, Miss Solomon?

20 MS. SOLOMON: I have no questions,
21 Mr. Commissioner.

22 THE COMMISSIONER: Miss Cronk?

23 MS. CRONK: I have just one question.

24 REDIRECT EXAMINATION BY MS. CRONK:

25 Q. Just one question, Miss Frise,



1
2 if I might. You recall, Miss Frise, that your
3 attention was drawn this morning, by Miss Symes, to
4 the meeting that took place on Monday, March 23rd
5 at Elizabeth Radojewski's house? Do you recall that?

6 A. Yes.

7 Q. And your attention was drawn,
8 again by Miss Symes, this morning to the question
9 which, as I understand it, you posed to Miss Costello
10 and you told Mr. Lamek about this. You asked her
11 whether or not some of the deaths, or what as you
12 described as the whole thing that had been happening,
13 had to do with digoxin?

14 A. Yes.

15 Q. That is the question you
16 asked her; do you recall that?

17 A. Yes.

18 Q. As I understood your evidence
19 last Thursday, Mr. Lamek asked you why you had posed
20 that question to Miss Costello, and you offered him
21 a number of reasons, and I would just like to review
22 those with you.

23 You told Mr. Lamek, as I recall it,
24 that you thought you asked that question because you
25 had been at work on Sunday - that would have been
Sunday, March 22nd?



1
E9

2 A. Yes.

3 Q. -- when you knew that the
4 digoxin had been locked up.

5 A. Yes.

6 Q. And that was one of the
7 reasons that you asked the question?

8 A. Yes.

9 Q. You also told Mr. Lamek, as
10 I understood it, that another reason you asked the
11 question was because when you were at work on that
12 Sunday, you had observed that supervisors were there
13 watching the nurses draw up digoxin and other
14 medications that were to be given to the patients on
15 the ward.

16 A. Yes.

17 Q. That was another reason?

18 A. Yes.

19 Q. And you also told Mr. Lamek,
20 as I understood it, that another reason you posed the
21 question was because you learned that very day, that
22 Monday afternoon, that Pacsai, Kevin Pacsai, had a
23 high digoxin level.

24 A. Yes.

25 Q. Do you recall saying that?

A. Yes.



Frise
re.dr. (Cronk)

1

E10 2 Q. And you learned as well that
3 there might be an inquest with respect to the death
4 of Kevin Pacsai.

5

A. That's right.

6

Q. Was that another reason why
7 you posed the question?

8

A. Yes.

9 Q. Then Miss Symes asked you
10 this morning, or she suggested to you, that there
11 might have been a problem with the strength of the
12 digoxin itself that was available on the ward; do
13 you recall that?

14

A. Yes.

15

Q. You told her, as I understood
16 it, that that as well was why you asked Miss
17 Costello that question about digoxin; do you remember
18 that?

19

A. Yes.

20

Q. Is it fair to say, Miss
21 Frise, it was the combination of all of those
22 factors and all of those things that you knew and had
23 observed that caused you to raise that matter directly
24 with Miss Costello that night?

25

A. Yes.

26

Q. And it was in that context that

27



Ell

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2 you asked her that question and that she gave the
3 answer you have described to us previously?

4

A. Yes.

5

MS. CRONK: Sir, I have no further
6 questions of this witness.

7

THE COMMISSIONER: No. Thank you.

8

MS. CRONK: Thank you, on behalf of
9 the Commission, Miss Frise.

10

THE COMMISSIONER: Thank you, Miss
11 Frise.

12

Now, we are in trouble.

13

MS. CRONK: I'm afraid we are, sir,
14 because our undertaking and representation, if you
15 will, to Mrs. Radojewski was that she would not be
16 available until 2:15 this afternoon. I can enquire
17 whether she can be available sooner, but I am afraid
18 I can give you no assurance on that.

19

THE COMMISSIONER: No. Do you know
20 anything further on this?

21

MS. SYMES: I'm sorry, I don't. I
22 can enquire as well.

23

THE COMMISSIONER: Let's see. Do
24 you happen to know where she lives, or is she working
25 or would she be at the Hospital?

26

MS. SYMES: Sir, she lives in the

27



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E12

west end of the city and the only problem is child
care for her new baby.

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THE COMMISSIONER: Well, she has
probably made all the arrangements for 2:15 and there
may be nothing we can do about it.

MS. CRONK: The only compromise
solution I can suggest, sir, I do not know whether it
will be possible, but I can attempt, through Miss
Symes, to contact Mrs. Radojewski, Mr. Commissioner,
and see if she could start earlier this afternoon
than 2:15.

THE COMMISSIONER: The trouble will
be getting the message around.

MR. LABOW: I just spoke to Mr.
Tobias and he had expected that Miss Symes would be
about an hour, and he is actually on his way.

THE COMMISSIONER: Where is he on his
way from?

MR. LABOW: Here, from his office.

THE COMMISSIONER: The trouble is
if we put him in -- well, I don't suppose there is
that much -- because if we have to -- well...

MR. LABOW: If we could take our
morning break a little earlier and then allow Mr.
Tobias his opportunity to cross-examine.



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E13

2 THE COMMISSIONER: As long as I can
3 also add that this will never, never, never happen
4 again. Poor Miss Frise, she is the one who has to
5 suffer for this. So, however, we will take our break
6 and we will come back when Mr. Tobias arrives. If
7 he arrives before quarter past eleven, but if he
8 doesn't, we will retire until 2:15.

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--- recess.



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---Upon commencing.

THE COMMISSIONER: Yes, Mr. Tobias.

MR. TOBIAS: Mr. Commissioner, I apologize for any inconvenience I may have caused to you or to other counsel and I recognize that this is a one time indulgence for which I thank you, sir.

CROSS-EXAMINATION BY MR. TOBIAS:

Q. Ms. Frise, I had an opportunity over the weekend to have a look at Exhibit 334 which is the 4B WINS Sheets. Am I correct that basically on March the 6th and 5th, 1981, that would have been the Thursday and Friday you were off?

A. Yes.

Q. All right. I take it that in fact you were off for three days. The record seems to indicate that Wednesday and Thursday were regular days off and Friday was a statutory holiday that you took off.

A. That's right.

Q. All right. So, you would have reported for work then I take it on the long night shift of Saturday, the 7th of March.

A. That's right.

Q. All right. And what time would you have reported for work?



Frise
cr. ex. (Tobias)

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A. 7:00.

3

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Q. All right. Now, my information
is that the Hines baby had been admitted to the
hospital early on the morning of Friday, March 6th,
although he was seen in emergency during the evening
of Thursday, March 5th. I take it that prior to coming
on duty on March 7th you had not seen the Hines baby.

5

6

A. That's right.

7

Q. And in fact when you had intended
to start your shift at 7 on the 7th you would have had
no previous contact with that baby and you didn't
even know that he was there; is that correct?

8

9

A. That's right.

10

11

Q. Okay, fine. Now, on the 7th
of March do you recall what your assignment was?

12

13

A. I had four babies in 431; I
can't recall the names of them.

14

15

Q. Okay, fine. If I can assist
you just for a moment.

16

17

I am looking, Mr. Commissioner, at
the 4B assignment book, page 117, it appears that
on March 7th --

18

19

THE COMMISSIONER: What exhibit is
that?

20

21

MR. TOBIAS: I am not sure that the

22

23

24

25



1

3 2 assignment book was a separate exhibit. It was 32A,
3 the entire book.

4 MS. CRONK: 13, sir.

5 MR. TOBIAS: And I am referring
5 specifically to the 4B assignment book now, page 117.

6 MS. CRONK: That's tab 14, sir.

7 THE COMMISSIONER: Thank you.

8 MR. TOBIAS: Q. Ms. Frise, from this
9 exhibit it appears Babies Ho, Baker, Singh,
10 Silva were in room 431 on the 7th as well as Hines.
11 There were five babies. Do you have a clear recol-
12 lection that Hines was not one of the babies that
13 you were caring for?

13 A. That's right.

14 Q. All right. Who was caring
15 for him?

16 A. Sue Reaper.

17 Q. So you would have been I take
18 it caring for the other four babies.

19 A. That's correct.

20 Q. Do you recall anything about
21 the medication that those other four babies were
22 on, can you assist me at all?

23 A. All I can recall is one baby
24 being on medication.

25



1

4

2 Q. All right. And what kind of
3 medication, was that baby on digoxin?

4 A. Yes, it was.

5 Q. All right. Now, are you telling
6 me that with respect to the other three you just
7 don't know what medication they were on?

8 A. I just don't remember at this
9 point.

10 Q. Okay, fine. As you know, there
11 has been evidence led here to indicate that the Hines
12 baby expired at around 6 a.m. on the 8th. So, I take
13 it that you would only have been present during
14 approximately the last 11 hours of the child's life.

15 A. That's right.

16 Q. Now, he went into arrest,
17 according to your note which appears in his
18 medical chart, at 4:10 a.m.

19 A. Yes.

20 Q. Did you have an opportunity to
21 observe the baby at all between 7:00 when you came
22 on shift and 4:10 a.m.?

23 A. Yes, I did.

24 Q. All right. Can you tell me what
25 his condition was at that time?

A. He was fine. I just looked at



1

5

the child.

3

4 Q. All right. Now, generally did you
note any discomfort or stress at all in his condition
or anything that would concern you whatsoever?

5

6 A. No, I did not.

7

8 Q. So, your recollection is that
he was stable.

9

10 A. Yes.

11

12 Q. Now, I take it from that, that
you did not at any time during those 11 hours hear
either of his monitors go off.

13

14 A. That's right.

15

16 Q. And you didn't observe him
17 being apneic or cyanotic.

18

19 A. That's correct.

20

21 Q. All right, fine. Now, were you
22 aware, do you have any personal information - I
23 don't want to know what you might have been told -
24 do you have any personal information as to any
25 episodes that Miss Reaper might have brought to your
attention with respect to the baby that evening?

21

22 A. Yes, there was one respect
23 where she had stated to me that the child's
24 apex was up to 180.

25

Q. All right. And was that basically



1

6

2 the only observation which she made that she com-
3 municated to you?

4 A. Yes.

5 Q. There were no other problems?

6 A. No.

7 Q. All right, fine. Now, can you
8 tell us, and I am referring, Mr. Commissioner, to
9 Exhibit 103 which is the Hines medical record,
10 particularly page 35 thereof, there is a note at
11 4:10, Miss Frise, in your own handwriting, it says:

12 "I, Meredith, was feeding a baby in
13 Room 431. Monitor on Jordan went off
14 and then stopped. I went to get up and
check him. At that moment the apnea
15 monitor went off."

16 Now, my first question to you is, the first monitor
17 to go off, was that his apnea or his cardiac monitor?

18 A. His cardiac monitor went off
19 first.

20 Q. All right. And once it came on
21 did it stay on?

22 A. No, it shut off.

23 Q. All right. How long was it on
24 for, do you recall, before it shut off?

25 A. Maybe a minute to two minutes.



1

7 2 What page is that on?

3 THE COMMISSIONER: Page 35.

4 MR. TOBIAS: Page 35.

5 A. Thank you.

6 Q. When the monitor went off the
first time what did you do?

7 A. I proceeded to get up to go
8 towards the child to see if there was a problem.

9 Q. Yes.

10 A. And I sat back down because it
11 had shut off.

12 Q. Because it...?

13 A. Had shut off.

14 Q. All right. So, did it shut off
15 basically in the length of time that it took you
16 to get up and approach the child?

17 A. I stood up out of the chair and
sat back down again.

18 Q. All right. Now, you just
19 previously told me that it might have stayed on
20 for a minute or two. I take it in light of what
21 you have just told me it was somewhat less than that?

22 A. It could have been.

23 Q. All right. Well, my point is
24 it wouldn't take you very long to get up and

25



1

8 2 approach the child, would it?

3 A. No. It could take a minute.

4 Q. All right. In any event, you recall
5 that before you got over to the child to attend to
6 him it went off?

7 A. Yes.

8 Q. All right. Then what did you do?

9 A. The monitor went off, it stopped,
10 I sat back down, the monitor went off again, I
11 proceeded to go over to the child.

12 Q. All right. Now, do you have any
13 recollection of how long transpired between the time
14 that it went off that it stopped sounding for the
15 first time and that you sat back down and it went
16 off again?

17 A. Not very long.

18 Q. All right. Are we talking just
19 a matter of moments?

20 A. Yes.

21 Q. Okay. And the second time it
22 went off, what monitor was it that went off, do you
23 know, was it the apnea or the cardiac monitor?

24 A. The cardiac monitor went off
25 and then the apnea monitor.

Q. All right. So, do I have it



1

2 correct then that the first time it was the cardiac
3 monitor only?

4

A. Yes.

5

Q. You got up, approached the
child and it stopped sounding?

6

A. Yes.

7

Q. You settled back down.

8

A. Yes.

9

Q. Moments later the cardiac

10 monitor goes off again.

11

A. Yes.

12

Q. You get up and approach the
child and thereafter the apnea monitor goes off as
13 well?

14

A. Yes.

15

Q. All right. What was the condition
16 of the child when you approached him with both
17 monitors going off?

18

A. When I approached the child the
child to my looking wasn't breathing. I touched
the child, there was no response, I shook the child,
there was no response.

21

Q. Yes. And what happened then?

22

A. At that point I called Mary
23 Jean Halpenny to come into the room.

24

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Q. Yes. Now, your note indicates
that when Mary Jean Halpenny came into the
room she started C.P.R. Did she start that im-
mediately?

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A. No, she did not. She left the
room because we weren't positively sure that the child
didn't have an apex. She left the room to get a
stethoscope.

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Q. Yes.

A. I didn't have mine around my
neck and neither did she. So, she left the room and
came back. When she left the room I put my baby back.
She checked, I checked and then at that point we
started C.P.R.

Q. All right. Now, how long was
she gone from the room, do you recall?

A. Not very long, maybe not even a
minute.

Q. Okay, fine. And when she was
out of the room were you still attending to the Hines
baby?

A. I had proceeded to put the baby
that I was feeding back into bed.

Q. All right. And then did you come
back to the Hines baby?



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A. Yes, I did.

3

Q. And were you there before she
got back with the stethoscope?

5

A. Yes, I was.

6

Q. What was his condition at that
time, was he breathing or not?

7

A. He was not breathing.

8

Q. All right, fine. So, I take it
that this incident at 4:10 was a fairly long period
in which he stopped breathing; do I have that
correctly?

12

A. When you say long period, long
period that we got to the child?

14

Q. No, the total amount of time that
you would have noticed him not breathing, would that
have been more or less than ten seconds.

16

A. More than ten seconds.

17

Q. Considerably more, can you
estimate for me at all how long that would have been?

19

A. No, I can't estimate, no.

20

Q. Do you recall if he changed
color?

21

A. Yes, he did change color.

22

Q. All right, fine. Was he cyanotic?

23

A. Yes, he was cyanotic.

24

25



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Q. Okay. And what happened after
Mary Jean Halpenny started C.P.R., do you recall?

4

5

A. She had pushed the alarm buzzer
and at that point Phyllis Trayner and Sue Nelles had
come in with the crash cart.

6

7

8

9

10

Q. Yes.

A. As well as Sue Reaper then

followed and Mary Jean started to bag the child and
Sue Nelles got in and started to do the compressions
on the child.

11

12

Q. All right. So, at that point
you were still in the room, I take it?

13

A. Yes.

14

Q. So, we have you, Sue Reaper,
Phyllis Trayner, Susan Nelles; was Mary Jean
Halpenny still there?

16

A. Yes, she was bagging the child.

17

18

Q. All right. Who else was there
at that point?

19

A. I said Susan Reaper, did I?

20

Q. Yes, you did.

21

A. No one else was there at that
point.

22

Q. All right. Now, I take it
ultimately a Code 25 was called?

24

25



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A. Yes, it was.

3

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Q. Do you recall what doctor responded to that Code 25?

5

A. Dr. Jeff Kobayashi.

6

Q. All right. And was there another doctor who later also joined him?

7

8

A. Yes, there was a few more doctors who joined him.

9

10

11

Q. I take it that one of those was Dr. Costigan, he has given evidence that he was there during the resuscitation effort.

12

A. Yes.

13

14

Q. All right. Do you recall how many doctors in total were there during the resuscitation effort?

15

A. Four or five.

16

17

18

Q. Okay. And was Dr. Costigan one of the doctors who was present during the whole resuscitation effort?

19

A. Yes, he was.

20

21

Q. And was Dr. Kobayashi another doctor who was present throughout the entire resuscitation effort?

22

A. Yes, he was.

23

Q. All right. Do you recall

24

25



Frise
cr. ex. (Tobias)

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14 2 the names of any of the other doctors who were there?

3 A. No, I do not.

4 Q. All right. Now, with respect
5 to nursing personnel.

6 A. Yes.

7 Q. Who was there throughout? In
8 other words, you have indicated five nurses that were
9 there when the Code 25 was called. Did they all stay
there throughout the entire resuscitation effort?

10 A. From my best recollection, every-
11 one stayed but Mary Jean Halpenny, she went out
12 and would pop in back and forth.

13 Q. I see, all right. So, you stayed
14 throughout the entire effort?

15 A. Yes.

16 Q. Susan Nelles and Phyllis
17 Trayner stayed throughout the entire effort?

18 A. That's correct.

19 Q. Sue Reaper stayed throughout the
20 entire effort?

21 A. That's correct.

22 Q. And in addition you said there
23 were three or four doctors.

24 A. Yes.

25 Q. Is that your best recollection



1

15 2 right now of all of the people who were involved in
3 the resuscitation effort?

4 A. Yes. I said four or five
5 doctors, didn't I?

6 Q. Now, I take it -- I'm sorry,
7 four or five doctors?

8 A. Yes.

9 Q. All right. Prior to the child
10 going into arrest, did you have any occasion whatsoever
11 to read his chart?

12 A. No, not that I can recall, no.

13 Q. All right. And when you came on
14 duty that night were you briefed on that child's
15 condition, did anyone discuss his condition with you?

16 A. Yes, I believe it was discussed
17 briefly at report.

18

19

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Q. All right. Do you recall what

was said at report?

4

5

A. I can recall that it was stated
that this child - they were worried about apnea spells.

6

Q. Yes. And that is why he was
on the monitor?

7

8

A. The apnea monitor, yes.

9

Q. Was anything else discussed at
report?

10

11

A. Something about bradycardia and
tachycardia.

12

Q. Yes. Anything else?

13

A. Nothing else that I can recall,
no.

14

Q. What was the impression that
you were left with as to the seriousness of the child's
condition at report?

15

16

17

18

19

20

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23

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Let me assist you. Was this a child
that they expressed any serious concern about? Was
he expected to deteriorate? Was he in any danger of
life threatening events?

A. No. No.

Q. Okay. Fine.

Now you told Mr. Lamek the other day
in giving evidence that you were surprised at the



G2

1

2 death of some of these babies. Certain babies expired
3 and you didn't expect them to?

4 A. Yes.

5 Q. And he asked you whether any
6 in particular stood out in your mind?

7 A. Yes.

8 Q. Your response was, "Well, right
9 off the top of my head, Jordan Hines"?

10 A. Yes.

11 Q. So I take it he stands out the
12 most in your memory in terms of surprise?

13 A. Yes.

14 Q. And unexpectedness?

15 A. Yes.

16 Q. Can you tell me why, what
17 caused you to give that response?

18 A. It was a surprise because we
19 were not told that this child was not going to - was
20 going to die. There was no warning beforehand that
21 this child died. There was no warning that this child
22 was in distress beforehand that we could jump in
23 before he passed away. It was just it happened very
24 quickly. The alarms went off and that was it.

25 Q. Was there anything else that
26 helped you form that opinion of surprise? In



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2 particular, how long normally would a resuscitation
3 effort go on for?

4 A. A normal resuscitation shouldn't
5 last any more than an hour.

6 Q. All right. How long did this
7 one last?

8 A. This one lasted to my best
9 recollection until about quarter to seven. We were
10 finished at quarter to seven.

11 Q. All right. He went into arrest
12 somewhere between 4:10 a.m. and 4:30?

13 A. That is right.

14 Q. So by my calculations that would
15 put it at almost two hours?

16 A. Yes.

17 Q. A little bit over two hours in
18 fact. Two hours and fifteen minutes?

19 A. Yes.

20 Q. Is that a particularly lengthy
21 resuscitation effort?

22 A. Yes, it was.

23 Q. Was there any significance to
24 that? Any special reason why the resuscitation effort
25 would go on for so long?

A. It would probably go on for so



G.4

1

2 long as they were - they couldn't understand why
3 this child passed away.

4 Q. Are you indicating that because
5 of the suddenness and because of the fact that this
6 was not a child who was expected to go into arrest
7 and who was expected to die, that he would have,
8 because of that, been a particularly good candidate
9 for resuscitation, and that is why they worked on him
for so long?

10 A. Yes.

11 Q. Is that basically what you are
12 saying?

13 A. Yes.

14 Q. All right. Fine.

15 Now I understand at the preliminary
16 hearing of this matter you gave some evidence
17 regarding an incident that occurred between Phyllis
18 Trayner and Susan Nelles during the arrest?

19 A. Yes.

20 Q. All right. And as you are aware
21 Miss Coulson who testified immediately prior to you
22 also gave some evidence as to that incident?

23 A. Yes.

24 Q. And I believe (correct me if I
25 am wrong) you were here last Wednesday when she was



G.5

1

2 giving that evidence, were you not?

3

A. Yes.

4

Q. So that you heard the evidence
5 given?

6

A. Yes.

7

Q. And you were familiar with it?

A. Yes.

8

Q. Can you tell me what incident
9 it is that I just referred to? What incident did you
10 give evidence about at the preliminary inquiry?

A. The pacemaker incident?

12

Q. Yes. What about the pacemaker?

13

What happened?
A. There was an argument between
14 Phyllis Trayner and Sue Nelles as to which pacemaker
15 should be used on the child.

16

Q. Okay. Now you chose the word
17 "argument". We have heard it characterized as a debate,
18 as a discussion, as an argument.

19

You tell us since you were there what
20 was it in your opinion?

21

A. It was a disagreement.

22

Q. Okay. Do you still stand by the
word "argument" that you used earlier? Were they
23 arguing or not?

24

25



G.6

1

2 A. They were disagreeing.

3

Q. Okay. Give me the intensity
4 of the disagreement? Was it a heated disagreement,
5 casual disagreement? Describe it to me, please.

6

A. I guess you can call it a
heated disagreement.

7

Q. Were they talking in ordinary
8 tones or were they hollering at one another?

9

A. They were not hollering at each
10 other.

11

Q. All right. You were there. Do
12 you recall what you were doing during the resuscitation
13 effort?

14

A. I was classified as the runner.
The surgeon was going to put in pacer wires.

15

Q. Yes.

16

A. I think I went to get the pacer
17 wires and asked him what size gloves he wore and got
18 the gloves and pacer wires set up on the counter for
19 him.

20

Q. All right. Now obviously you
noticed this disagreement?

21

A. Yes, I did.

22

Q. Did you find it disturbing in
23 the context of the resuscitation effort or not?

24

25



G.7

1

2 A. I would say it was disturbing,
3 yes.

4 Q. Did it in any way interfere with
5 those duties that you had to perform during the
6 course of the resuscitation effort?

7 A. No, it did not.

8 Q. Do you have any information as
9 to whether or not it interfered with any of the other
10 members present, members of the resuscitation team?
Did anyone say anything to you afterwards?

11 A. No, they did not.

12 Q. Fine. How long did this dis-
13 agreement go on for?

14 A. Twenty minutes.

15 Q. Okay. And while this disagree-
16 ment was going on what were the doctors doing?

17 A. They were working on the child.

18 Q. All right. And in particular,
19 can you assist me as to what they were doing?

20 A. They were prepping the child
21 to put in pacer wires.

22 Q. Yes. What was the argument
23 about, do you recall?

24 A. Yes. It was about which kind
25 of pacemaker they were going to use.



G.8

1

2

Q. All right. Now were you there
when the doctor called for a pacemaker?

4

A. Yes, I was.

5

Q. Did he indicate what kind of
pacemaker he wanted?

6

A. No, he did not.

7

Q. And as far as you know - I take
it you have been in on resuscitation efforts before?
This was not the first time?

10

A. That's correct.

11

Q. How many have you participated in?

12

A. I don't know the number.

13

Q. Well, are we talking more than 10?

14

A. You could say 10. More than 10.

15

Q. Okay. And have you had any
previous experience with pacemakers?

16

A. Yes, I had.

17

Q. I take it you have been there
before during a resuscitation effort when pacemakers
were used in aid of the resuscitation effort?

20

A. It was talked about, yes, but
never ever brought in and used.

21

Q. I'm sorry? I didn't hear.

22

A. It was talked about but it was
never ever brought in and used.

24

25



G.9

1

2

3 Q. All right. Do you know - do you
4 have any information as to whether it makes a difference
5 to the resuscitation effort itself as to what kind of
6 pacemaker you use?

7 A. Yes, it would.

8 Q. Okay. Can you tell me what

9 that difference is?

10 A. There are two different pace-
11 makers. One pacemaker is a demand pacemaker. The
12 other one is a sequential pacemaker.

(2)

13 Q. Yes.

14 A. And it involves in the demand
15 pacemaker the child's heart can beat on its own, and
16 the demand pacer will kick in when the child's heart
17 goes below a certain rate.

18 Q. Yes.

19 A. The sequential pacemaker will
20 help the child's heart just beat, period.

21 Q. I see. So, that in terms of the

22 utility of it, it would be the second kind of pacemaker

23 that you refer to --

24 A. Yes.

25 Q. -- that would be the more

desirable?

A. Yes.



G.10

1

2

Q. But do you agree with me that
both kinds would get an impulse going?

4

A. That's correct.

5

Q. And isn't that really what you
are trying to do when a child is in cardiac arrest?

6

A. Yes.

7

Q. Get an impulse going?

8

A. Yes.

9

Q. And doesn't it matter how fast
you get that done?

11

A. Does it matter how fast?

12

Q. How fast you get the impulse
going? I take it it is good; it is something that you
want to accomplish if you can get it done very quickly?

14

A. Yes.

15

Q. And in that regard it really
wouldn't matter, would it, because either pacemaker
would get an impulse going?

18

A. Yes.

19

Q. And the real issue is that you
should get the pacemaker as quickly as possible?

21

A. That is correct.

22

Q. All right. Fine.

23

Now, Miss Coulson gave evidence that
at one point during this discussion Dr. Costigan had

24

25



G.11

1

2 to ask Susan and Phyllis to be quiet, and I believe
3 her words were "Let's calm down, ladies".

4 Do you recall him saying that?

5 A. I have to say, no, I can't
6 recall him saying that.

7 Q. All right. You weren't there,
8 though, at all times during the resuscitation effort
9 because you were a runner as you have indicated?

10 A. Yes. Yes.

11 Q. So that I take it there were
12 brief time periods when you would have been out of
13 the room?

14 A. Yes, but I wasn't out of the
15 room right at the initial argument or disagreement
16 over the pacemaker.

17 Q. And were you in the room the
18 entire time that argument or disagreement was ongoing?

19 A. Yes.

20 Q. Fine. You have no recollection
21 of the doctor having to ask them to --

22 A. No, I can't remember.

23 Q. -- to quiet down?

24 A. No.

25 Q. Did you think that it was a good
idea for them to quiet down?



G.12

1

2

A. Yes, it would have been a good
idea.

4

Q. Do you agree with me that this
discussion really didn't do much to aid and advance
the resuscitation effort?

6

A. Yes, that's right.

7

Q. It would have been better
frankly if it hadn't happened? Do you agree with that?

9

A. Yes.

10

MR. TOBIAS: All right. Fine.

11

Those are all my questions.

12

THE COMMISSIONER: Yes. All right.

13

Thank you.

14

Miss Solomon?

15

MS. SOLOMON: No questions.

16

THE COMMISSIONER: Miss Cronk?

17

MS. CRONK: No questions, sir.

18

THE COMMISSIONER: We once again thank
you and I suggest that you make a very speedy retreat
from here before somebody else turns up.

20

--- Witness withdraws

21

THE COMMISSIONER: Now what about the
room?

22

MS. CRONK: Sir, we have a room,
Hearing Room No. 3.

24

25



G.13

1

2

THE COMMISSIONER: For when, this
afternoon?

4

MS. CRONK: This afternoon.

5

THE COMMISSIONER: This afternoon at
2 p.m.?

6

MS. CRONK: Yes.

7

THE COMMISSIONER: All right. We are
going to ask counsel to meet in Hearing Room No. 3.

9

MS. CRONK: Hearing Room No. 3 at 2 p.m.

10

THE COMMISSIONER: At 2 p.m. this
afternoon. It has to do with the evidence, and it is
a meeting in camera so we will meet at 2 o'clock.

11

MS. CRONK: It being the intention
then, sir, that we will resume at 2:15 or as shortly
thereafter as we can.

12

THE COMMISSIONER: That is right.

13

--- Luncheon recess.

14

15

16

17

18

19

20

21

22

23

24

25



AA
DM/PS

1

2 ---Upon resuming at 3:05 p.m.

3

THE COMMISSIONER: Yes, Ms. Cronk.

4

MS. CRONK: Good afternoon, sir. Our
5 next witness, sir, is Ms. Elizabeth Radojewski.

6

ELIZABETH RADOJEWSKI, sworn.

7

DIRECT EXAMINATION BY MS. CRONK:

8

9

10

11

Q. Ms. Radojewski, it is sometimes
difficult to hear in this room and I would ask you if
you could when you have your discussions over the next
day or so if you could just lean forward to the mike
a little bit.

12

13

14

As I understand it, Ms. Radojewski,
you enrolled in a Registered Nursing Diploma
Course at the Hospital for Sick Children in
September of 1967, is that correct?

15

A. Yes, I did.

16

17

18

Q. You graduated from that course
successfully in 1970 with a Registered Nursing
Certificate?

19

A. Yes.

20

21

Q. You were then that very year, in
September, hired by the Hospital for Sick Children as
a Staff Nurse?

22

A. Yes, I was.

23

Q. What ward did you first work on

24

25



1

2 at the Hospital for Sick Children?

3 A. I worked on the Burn Unit,
4 Ward 8E.

5 Q. And you were transferred, as I
6 understand it, at a subsequent point to the
7 Cardiac Unit, that was in 1972, I have been informed?

8 A. Yes.

9 Q. And was that on Ward 5A at the
time?

10 A. Yes, it was 5A.

11 Q. And initially were you employed
12 on that ward as the staff nurse?

13 A. Yes.

14 Q. Did you then subsequently become
15 promoted to the position of team leader on Ward 5A?

16 A. Yes, I did.

17 Q. And subsequently as a teaching
team leader again on the same ward?

18 A. Yes.

19 Q. In October, 1975 I have been told
20 that you left the Hospital for Sick Children on an
21 educational leave of absence for approximately six
22 months.

23 A. Yes.

24 Q. And where did you work during that

25



1

3 2 six month period?

3 A. I worked at Great Ormond Street
4 Hospital in London, England.

5 Q. And that was, as I suggested, for a
6 six month period?

7 A. It was either six to eight months,
8 I am not quite sure.

9 Q. Did you then return to Toronto
10 into employment at the Hospital for Sick Children?

11 A. Yes, I did.

12 Q. In what capacity?

13 A. Staff nurse on Ward 7G which
14 was the Neonatal Intensive Care Unit.

15 Q. And subsequently did you again
16 return to the cardiac unit?

17 A. Yes, I transferred back to 5A.

18 Q. Do you recall now when that was?
19 Was this shortly after your return to the Hospital
20 for Sick Children?

21 A. I spent about, between six to
22 eight months in the neonatal ICU, so it was after
23 that time I transferred, I believe it was December
24 or November.

25 Q. And that would have been in
1976?



1

2 A. Yes.

3

4

5

Q. And when you returned to Ward 5A did you return to the position you formerly held, and that is a teaching team leader on that ward?

6

A. Not immediately.

7

Q. Subsequently you again achieved that position on the ward?

8

A. Yes.

9

Q. What position did you hold on Ward 5A at the beginning of March, 1980, Ms.

10

Radojewski?

11

A. Teaching team leader.

12

Q. And when the ward relocated to Wards 4A and 4B you were promoted as we have heard to head nurse on Ward 4A, is that correct?

13

A. Yes.

14

Q. And Mary Costello had been the previous head nurse on Ward 5A in its entirety?

15

A. Yes.

16

Q. She then assumed the position of head nurse on Ward 4B, effectively the same time as you assumed those duties for Ward 4A, is that correct?

17

A. Yes.

18

Q. During the period April, 1980, through to the end of March, 1981, did you continue to

19

20

21

22



1

2 hold the position of head nurse for Ward 4A?

3 A. Yes, I did.

4 Q. You do not, as I understand it,
5 hold that position today, is that correct?

6 A. That's correct.

7 Q. You left the employ of the
8 Hospital for Sick Children at some point after
9 April of 1981?

10 A. Yes, I did.

11 Q. When was that?

12 A. I left the employment in
13 February of 1982 on maternity leave.

14 Q. Since then have you returned to
15 work outside the home with any medical care institu-
16 tion?

17 A. No, I have not.

18 Q. Counsel has been kind enough to
19 provide to me, Ms. Radojewski, a copy of your curriculum
20 vitae. Could you look at it for a moment please,
21 and tell me if it accurately sets out your educational
22 and employment background?

23 A. Yes, it does.

24 THE COMMISSIONER: Exhibit 363.

25 MS. CRONK: 363, sir?

26 THE COMMISSIONER: That's right.



1

2 MS. CRONK: Thank you.

3

3 ---EXHIBIT NO. 363: Curriculum vitae re. Elizabeth
4 Radojewski.

5

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Q. Ms. Radojewski, I would ask you to look for a moment if you would at the time period described on your curriculum vitae for the period when you were on six month educational leave of absence, it is expressed as having been the period of October, 1975 to April, 1981, I assume that that is a typographical error?

A. Yes.

Q. And it should read through April, 1976.

A. That's right.

Q. Thank you. Ms. Radojewski, on the basis then of the various positions that you have held at the Hospital for Sick Children, and as well the positions that you held in London, England, do I have it correctly that by July of 1980 you had had almost 8 years of experience as a nurse in pediatric cardiology?

A. Yes.

Q. When you were employed as the head nurse for Ward 4A, can you tell us please what your normal hours of duty were?

.



1

2

A. The normal hours were 7:15 in the morning until 3:45 p.m.

4

5

Q. Did you on occasion work the long night shift or the evening shift?

6

7

A. No, I did not.

8

Q. Did you have occasion from time to time to work the weekends as the head nurse on Ward 4A?

9

10

A. Not in the capacity of the head nurse, I did work weekends occasionally.

11

12

Q. And in what capacity would you do that?

13

A. As a nursing supervisor.

14

Q. How often would you do that?

15

A. It was about one in eight weeks.

16

Q. Once every eight weeks you would work both days of the weekend, Saturday and Sunday?

17

A. Usually Saturday and Sunday.

18

Q. As a nursing supervisor did you have responsibility on those weekends for Ward 4A and Ward 4B?

19

A. Yes, I did.

20

Q. Would you have then been the only nursing supervisor in the hospital on those two days?

21

22

23

24

25



1

2 A. No, I wasn't.

3

4 Q. How many would have been on duty

from time to time on those weekends?

5

6 A. There was an area coordinator
7 who was in charge of the whole hospital, and again
8 another head nurse from the medical area.

9

10 Q. So two to three at any given
time?

11

12 A. Usually the three of us were on
13 the weekends.

14

15 Q. When you were assigned to work
16 weekends were you invariably assigned to supervise
17 Wards 4A and 4B?

18

A. Yes.

19

20 Q. When you were on Ward 5A, that is,
21 before the relocation of the cardiology unit to
22 Wards 4A and B, Ms. Radojewski, did you have occasion
23 then to work long night shift duty?

24

A. Yes, I did occasionally.

25

26 Q. And did you as well have occasion
27 then to work the evening shift duty from time to -
time?

28

29 A. No, I believe I just worked
30 long night duty.

31

32 Q. When you were working on 5A did

33



1

2 you have occasion to work with Susan Nelles?

3 A. On 5B?

4 Q. Yes.

5 A. Yes, I did.

6 Q. Did you have occasion as well to
work with Phyllis Trayner on Ward 5A?

7 A. Yes, I did.

8 Q. Did you have occasion to work with
9 the other members of the Phyllis Trayner nursing
10 team on 5A?

11 A. Yes.

12 Q. With the exception, I take it, of
13 Janet Brownless.

14 A. Yes, and Mrs. Scott.

15 Q. You did not work with Mrs. Scott
on Ward 5A?

16 A. Oh, I'm sorry, I did.

17 Q. Do I have it correctly that you
18 did have occasion to work with all of the members of
19 Phyllis Trayner's nursing team on Ward 5A with the
exception of Janet Brownless?

20 A. Yes.

21 Q. We have heard from Ms. Costello
22 that her duties as head nurse on Ward 4B included
23 management of patient care, ensuring the quality of

24

25



1

2 patient care, ensuring as she described it, the
3 patient's nursing needs were analyzed and were met
4 on a timely basis; the management of staff needs
5 including budget responsibilities. In broader, general
6 terms, Ms. Radojewski, is that an accurate description
7 of what your own duties and responsibilities were as
head nurse on Ward 4A?

8

A. Yes, it is.

9

10 Q. Did your duties require you as
head nurse to monitor and assign specific nursing
11 duties by various nurses who worked on 4A?

12

A. Yes, it did.

13

14 Q. Can you help us please, in
respect of the assigning of patient assignments, when
would you perform that function on a daily basis?

15

16 A. I would do the patient
17 assignments for the shift from 3 to 7 p.m. when I
18 came on in the day; and I would do the assignment
19 for the long night shift that day; and I would do
the assignment for the next day from 7 until 3.

20

21 Q. And in assigning various nurses
22 to the care of specific children, I take it then that
23 on any given day when you were working the eight hour
day shift, you would plot the assignment effectively
for the next 24 hours.

24

25



1

2 A. Yes.

3

4

Q. Did you record those in the
assignment books that we have heard were maintained
on Ward 4A?

5

A. Yes, I did.

6

7

8

9

Q. And when the long night staff,
particularly the team leader on long nights came in
to work would it be within her authority to check the
patient assignments you had made during the day?

10

A. If she felt that she had to, yes.

11

12

Q. And if she were to do so would
that be recorded in a special or specific way?

13

14

A. She would usually erase the
assignment that I had done and put in her own, and
I was told verbally about it the next morning.

15

16

17

18

19

Q. When you say she would erase the
assignment that you had done, I take it she would
actually erase the entry that you had made in the
assignment book and replace it with the name of the
individual she was assigning?

20

A. Yes.

21

22

23

24

25

Q. And with respect to the assignments which were to apply on weekends, did your
responsibilities extend on Fridays to assigning
specific nurses to specific patients for weekend



1

2 duty?

3 A. I did the assignment for the
4 day shift on Saturday from 7 until 3.

5 Q. Did you do any other assignments
6 for weekend duty?

7 A. No.

8 Q. Whose responsibility was it to
9 complete those assignments?

10 A. The team leader in charge of the
11 ward for the weekend.

12 Q. And would that be the team leader
13 who assumed duty on the long night shift on Friday
14 evening?

15 A. It was usually the team leader
16 who was in charge on the day shift, 7 to 3 on
17 Saturday.

18 Q. On Saturday?

19 A. Yes.

20 Q. And in addition to the other
21 general responsibilities that you have outlined for
22 us, what specific staff were you responsible for
23 on an ongoing basis as head nurse on 4A?

24 A. Specific staff, the teaching
25 team leader had some responsibility to me; the
team leaders; registered nurses and registered nursing



1

2 assistants.

3

4 people was your responsibility confined to
5 those who worked on 4A as distinct from 4B?

6

A. Yes.

7

8 Q. When you say you were responsible
9 for the team leaders on 4A and the registered nurses,
10 I take it then that you would have been responsible
11 for all of the nursing teams that were classified
12 as 4A teams?

13

A. Yes.

14

15 Q. And that would include Phyllis
16 Trayner's nursing team?

17

A. Yes, it would.

18

19 Q. Did your staff development
20 responsibilities, if I can describe them as such,
21 extend to the undertaking from time to time of written
22 staff evaluations?

23

A. Yes, it did.

24

25 Q. And did your responsibilities in
that regard extend both to registered nursing
assistants and to registered nurses who worked on
4A?

26

A. Yes.

27

Q. Can you take us very briefly

28

29



1

2 through your responsibilities on an average 8 hour
3 day shift when you were working, Ms. Radojewski? What
4 would the very first thing be that you would do when
5 you arrived at work?

6 A. Usually I arrive shortly after
7 7, and I would just have a small chat with the people
8 on night to see how the night had gone and if there
9 were any problems with the staffing. At 7:15 I
10 would go in to take report with the rest of the
11 nurses from the ward that were on duty that day.
12 That would take anywhere from 20 to 30 minutes.
13 When we came out the team leader and I would go
14 over our plan for the day, such as children going
15 for different tests. We would, if there were
16 relief staff to be oriented to the ward for that day,
17 she would look after that. If there was time we did
a nursing round before we took the residents on rounds.
Meaning --

18 Q. I'm sorry, go ahead.

19 A. If the team leader was new on
20 duty that day, had been off for a couple of days, then
21 I would take her around and refresh her memory and tell
her what had gone on in the past two or three days.

22 Q. If I could stop you there for
23 a moment. You have told me that at approximately 7:15

24

25



1

2 in the morning you would take report?

3 A. Yes.

4 Q. And where normally did you take
5 that, where was the physical location on the ward
6 where you took report?

7 A. Yes, 4A took their report in the
8 conference room.

9 Q. And who was expected to be at
10 report, other than yourself?
11 _____

12

13

14

15

16

17

18

19

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21

22

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BB

BMcrc 3

A. The nurses who were on duty
for that day and night nurse who gave us report.

Q. And you told us that that
would take anywhere from 20 to 30 minutes, so I take
it by twenty-five to eight or a quarter to eight
in the morning normally you would be finished taking
report?

A. Yes.

Q. All right. And then time
permitting you would do a series of nursing rounds?

A. Yes.

Q. All right. And who would
accompany you on those rounds?

A. Usually it was just the
team leader and I.

Q. All right. And what was the
purpose of that?

A. That was really to bring her
up to date on things that had gone on on her days
off.

Q. All right. And you have
mentioned something as well about rounds that you
did with Residents.

A. Yes.

24

25



1

BB2 2

Q. When were they done?

3

A. From eight until eight-thirty.

4

Q. And who would accompany you
on those rounds other than the Residents?

5

A. The team leader would come
as well.

6

Q. And how long would they
normally take?

7

A. Anywhere from 20 to 30
minutes.

8

Q. We have heard as well that
at nine o'clock in the morning on Wards 4A/4B there
were certain specific medications that were required
to be given to patients including the drug digoxin.
Does that accord with your recollection of the practice
on the ward?

9

A. Yes.

10

Q. All right. Did you as head
nurse have any involvement in overseeing or checking
the digoxin medications that were to be given at
nine o'clock in the morning on the day shift?

11

A. No.

12

Q. All right. Did you have any
responsibility to ensure as head nurse that those
medications had been given, given in the correct

13

14



1

BB3 2 amount and to the correct patient?

3

4 given to the team leader and the night nurse in
5 charge usually checked to see that they had been
6 given when she did her paperwork at night.

7

8 Q. All right. Now, after you
9 had completed the rounds with the Residents and with
10 your day shift team leader what normally would your
11 duties then encompass, very briefly?

12

13

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A. The team leader and I shared
transcribing of doctors' orders, if there were any
orders before they went off to their other meeting
at 8:30, we would look at placement - we had already
assigned the placement of admissions the day before
usually, but occasionally we had extras in. We
would look at placement of transfers. There would be
time hopefully to go through the charts, and that
didn't happen every day. I am not sure what else
you're asking for the rest of the day.

Q. All right. You have told

me that you did do rounds at the beginning of the
day with the team leader and also rounds with the
Residents when they arrived on the ward. Would there
be any occasion after nine o'clock in the morning
through to the end of your shift at about 3:45 in

15.1

25



1

BB4 2 the afternoon when you would have occasion on a
3 regular basis to again do a nursing round?

4 A. Yes, I did a nursing round
5 with my team leader before I left for the day.

6 Q. All right. And at what time
7 during the day approximately according to routine
would you do that round?

8 A. That occurred usually anywhere
9 from 2:30 until four.

10 Q. All right. Do I have it
11 correctly then that on a regular basis you, as the
12 head nurse on that ward, would see each child on the
13 ward perhaps briefly but nonetheless see the child at
14 least three times every day?

15 A. Yes.

16 Q. And were there occasions when
17 you did nursing rounds more than twice on an 8-hour
day shift?

18 A. Yes, there were when the
19 cardiologists were in charge, depending on the
20 cardiologist in charge of the ward. There were his
21 rounds at certain times of the week.

22 Q. All right. So that you could
23 see each patient on the ward as many as four times
24 during the day?

25



Radojeswki
dr.ex. (Cronk)

BB5

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A. Yes.

2

3

4

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6

Q. And that's assuming that no emergency or critical condition had arisen in which case you would see I take it the patient again at that time?

7

A. Yes.

8

9

10

Q. All right. At the end of your shift, again an 8-hour day shift, was there a formal report in which you participated to brief the oncoming nurses?

11

A. No.

12

13

14

Q. All right. How then was the status of the patients on the ward communicated to the evening nursing shift when you left?

15

16

A. The team leader would give report to any nurses that were coming on from what you call the evening shift from three to seven.

17

18

19

A. And you have told us that your hours normally on an 8-hour day shift terminated at about 3:45 in the afternoon?

20

A. Not always, but yes.

21

22

Q. Well, when as a matter of normal routine would you leave the ward when you were working an 8-hour day shift?

23

A. Usually it was after four.

24

25



1

BB6 2

Q. Much after four?

3

A. No, no, close to four.

4

Q. All right. Can you tell us as well, Mrs. Radojewski, for the benefit of understanding what happens on the wards during the days whether or not there were relatively fixed intervals for the taking of breaks by nurses during the day shift?

9

A. Usually their break time occurred anywhere from 9:30 until quarter to eleven in the morning, and that's taking into account the time that they spend waiting for the elevator and coming back from the cafeteria.

13

Q. All right. Was that at that point a coffee break or a lunch break?

14

A. That was a coffee break.

15

Q. Were they as well entitled to a lunch break during the course of the day shift?

16

A. Yes, they were. That usually started about 11:30 or quarter to twelve and that could happen until 1:30.

17

Q. Were there any other breaks during the course of a normal day shift to which the nurses under your charge were entitled?

18

A. They would start an afternoon

19

20

21



1

BB7

2

coffee break, the nurses that were on a 12-hour day. They could start that at 2:30 and that may go on until about just before four.

5

6

7

Q. And whose responsibility was it to assign for any given nurse on the day shift the timing of her particular breaks?

8

A. It was usually the team leader's job.

9

10

11

12

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25

Q. If the nurse who was entitled to take either a coffee break or a lunch break on the day shift had been assigned to constant nursing care duties, whose responsibility was it to assign a relief nurse to take over her responsibilities while she was on her break?

A. It was the team leader's duty to assign but we often checked it over together.

Q. All right. Would there be any record kept of those nurses who relieved for constant care nurses during the day?

A. There may have been some notations made on the assignment book.

Q. Was that required or would that be simply a matter of fortune, if you will, if you were trying to go back and determine it?

A. A matter of fortune.



1

BB8 2

Q. It wasn't required that a record be kept?

4

5

6

7

A. We had a large piece of paper that also was the assignment for the day posted on the ward and that is where it was written down definitely, but it didn't always make it into the assignment book.

8

9

Q. Were those sheets of the daily assignments kept on a regular basis?

10

A. No, they were discarded.

11

12

13

Q. All right. Were they discarded on a daily basis or were they accumulated over a period of time and then destroyed?

14

A. I believe they were discarded on a daily basis by the ward clerks.

15

16

17

18

19

20

Q. You have told us, Mrs. Radojewski, that although you did not work the long night shift on Ward 4A, you did have that experience on Ward 5A and of course some of your own nurses on Ward 4A would on occasion be working the long night shift. Do I have that correctly?

21

A. Yes.

22

23

24

25

Q. To the best of your knowledge, were there fixed intervals at night when nurses were to take their entitled break periods?



1

BB9 2

A. I don't recall that they were actually fixed times. In my recollection, the nurses tended to take their breaks at times that were less busy, that is, at peak times they didn't take their breaks and those were usually times when vital signs were being taken, infants needed to be fed and if there were any treatments to be done they took them at less busy times. It was not as structured as it was on days..

10

11

12

13

Q. Well, do I have it that nurses who were working the long night shift would be entitled, as were their counterparts during the day, to at least two coffee breaks and a lunch or dinner break?

14

15

A. Yes, they often combined them, but yes.

16

17

18

19

Q. All right. Well, assuming that they took them separately, we have heard that there were set medications that were to be given at nine o'clock on the ward during the long night shift.

20

A. Yes.

21

22

23

Q. Would it be your expectation that any of the nurses on Ward 4A would take a coffee break before the giving of those nine o'clock medications?

24

25



1

BB1 2

A. Not usually, no.

3

Q. And that would be I take it
a relatively busy time on the ward?

4

A. Extremely busy.

5

Q. So, would it be fair of us
then to assume that the first coffee break period
would commence after the giving of the nine o'clock
medications?

6

A. Yes.

7

Q. All right. Similarly, having
regard to what you know of the activity on the ward
during a long night shift, is there a time period
within which you would have expected the nurses to
take their lunch or dinner breaks?

8

A. Yes, there is a time period.

9

Q. When would that be, between
what hours?

10

A. More than likely between
one-thirty and three and then again perhaps a short
break before the morning, but the first few hours of
the morning shift, meaning the end of their shift,
are extremely busy as well.

11

Q. So that in the normal course
of events I take it you would not expect nurses to
take their lunch or dinner break on the long night

12

13



1

BB11 2 shift before one in the morning?

3

A. I don't think so.

4

Q. All right. And then finally
they would be entitled to a second coffee break some
time before the shift ended at 7:15 in the morning?

6

A. Yes.

7

Q. All right. Now, you have
told us that the giving of medications --

9

MR. HUNT: I'm sorry, I'm confused
about that, Mr. Commissioner. I thought the witness
had said that it was between 1:30 and three that it
was extremely busy.

13

THE COMMISSIONER: No, I thought that
was --

14

MS. CRONK: The lunch break.

15

THE COMMISSIONER: Well, perhaps I'm
wrong but I thought that's when you expected the
lunch break to be, isn't that correct?

18

THE WITNESS: Yes.

19

THE COMMISSIONER: It's not a parti-
cularly busy time, or is it?

20

21

22

23

24

25

THE WITNESS: The nurses do a vital
sign routine usually every four hours. That's the
usual routine unless there is something more going on.
So, they are busy at twelve and at four. So, very



1

BB12 2 often between twelve and four there is a long lunch
3 break on nights.

4

5 MR.HUNT: The thing I think that
6 confused me was I thought the witness said the first
7 few hours of the early morning are busy.

8

9 THE WITNESS: I'm sorry. I referred
10 to that as the end of the long night shift.

11

12 MR. HUNT: What hours?

13

14 THE WITNESS: That's what it means to
15 me, because I work days.

16

17 MR. HUNT: What hours were you re-
18 ferring to?

19

20 THE WITNESS: The first few hours that
21 were busy?

22

23 MR. HUNT: Yes.

24

25 THE WITNESS: Usually between four
and seven.

26

27 MR. HUNT: Oh, all right, I see,
28 thank you.

29

30 MS. CRONK: Q. So that I understand
31 it as well and I should clear this up for others
32 including myself, you have told us that there are
33 a number of busy times during the course of a 12-hour
34 long night shift.

35

36 A. Yes.

37

38



Radojewski
dr.ex. (Cronk)

BB13

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2

3

4

Q. And do I have it correctly

that one of those times is at 9:00 or thereabouts for
the giving of medications at nine o'clock?

5

A. Yes.

6

7

8

9

Q. All right. Is that the first
period that you would expect, other than the period
when they were taking report and coming on duty,
that would be particularly busy for those long night
shift nurses?

10

A. Yes, it is a busy time.

11

12

13

Q. When after the giving of the
nine o'clock medications would you expect it next to
be a particularly busy period on the ward?

14

15

A. If there are a lot of children
on vital signs every four hours, the next busy time
is twelve.

16

17

Q. All right. And that is because
vital signs would be taken at that time?

18

19

A. Yes, and usually children
wake up.

20

21

Q. As a standard matter was it
a usual and frequent practice that vital signs were
ordered every four hours?

22

23

A. It was the routine pretty well.

24

25

Q. All right. So then do I take



1

BB14 2 it correctly that they would be taken at eight o'clock
3 in the evening?

4 A. Yes.

5 Q. And then at twelve o'clock?

6 A. Yes.

7 Q. And then again at four o'clock?

8 A. Yes.

9 Q. Between the hours shortly
10 after midnight when those vital signs had been
11 completed at four o'clock in the morning, would there
12 be any particular period in those four hours which
13 you would expect to be busy for the nurses on that ward?

14 A. Unless there was something
15 else that needed to be done, like treatments or
16 infants being fed.

17 Q. There would not be?

18 A. I don't think so.

19 Q. All right. So that during that
20 period you have told us you think starting at about
21 1:30 in the morning nurses would take their lunch
22 or dinner break?

23 A. Yes.

24 Q. And then at four o'clock in
25 the morning if vital signs were being taken again
that would be another busy period?



1

BB15

A. Yes.

3

4

Q. All right. And would there
be another particularly busy period between four in
the morning and 7:15 in the morning when the shift
ended?

5

6

A. Usually after six, from six
until the shift ended was a busy time.

7

Q. And why was that?

9

10

11

12

A. There may have been children
to prepare for the operating room, children to pre-
pare for cardiac cath. There was charting to be
done as well and it was a busy time.

13

14

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EMT.jc

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Q. During those periods during
the 12-hour night shift when it was busy for the
nurses on 4A, I assume that each would have her
particular duties and responsibilities to fulfil.

3

A. Yes.

4

Q. Would it be fair of us to
assume as well that during those peak periods if
I can describe them that way, none of the nurses
would be on a break but rather they would be
attending to what their particular duties were at
the time?

5

A. I would hope not.

6

Q. Most of them would be on the
ward if not all of them?

7

A. Yes.

8

Q. What does the term "constant
nursing care" mean to you, Mrs. Radojewski, as Head
Nurse of Ward 4A?

9

A. Constant nursing care means
that there is one nurse to look after the needs of
the patient, of one patient, and it usually implies
that the child is of a critical nature.

10

Q. In a critical condition?

11

A. Yes.

12

Q. When you worked as the Head Nurse

13

14



CC.2

1

2 of 4A assigning nurses to constant nursing care did
3 you differentiate between registered nurses and
4 registered nursing assistants?

5 A. Yes, I did.

6 Q. Who would normally be assigned
7 to constant nursing care duties?

8 A. Usually a registered nurse was.

9 Q. When a nurse who had been
10 assigned constant nursing care duties was to take a
11 break, whether it be an official or unofficial one,
12 was there a rule or practice in place on the ward
13 insofar as you were aware that dictated who was to
14 relieve her?

15 A. I don't know that there was
16 a rule but it was understood that a nurse of equal
17 calibre would then relieve for the constant care nurse.

18 Q. Were there situations then
19 when registered nursing assistants would relieve for
20 registered nurses?

21 A. There may have been on occasion.

22 Q. As Head Nurse on 4A would that
23 in your view be a desirable practice?

24 A. No, it was not a desirable
25 practice.

Q. Did you encourage that?



CC.3

1

2 A. No, I did not.

3

Q. Was it then your preference that
4 a registered nurse relieve a registered nurse?

5

A. Yes.

6

Q. Was there any procedure in
7 place insofar as you are aware on Ward 4A at night
8 which suggested that registered nursing assistants
9 could relieve registered nurses who had been assigned
to constant nursing care duties?

10

11

A. Can you repeat the beginning
of that again, please?

12

Q. I am sorry, it is an awkward
question.

13

14

Was the situation any different at
night insofar as you are aware?

15

16

A. No. I don't believe that it
was different.

17

18

19

Q. Was it still expected that a
registered nurse then would relieve a registered nurse
if she had been assigned to constant nursing care
duties?

20

21

A. Yes.

22

23

Q. You have told us as well that
once in approximately every eight weeks you worked
weekends as a nursing supervisor, and when you did so

24

25



CC. 4

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2

you would have responsibility for Ward 4A. Do I
have that correctly?

3

A. Yes.

4

Q. When you did so what were your
normal hours of duty?

5

A. They were similar, from 7:15 a.m.
to 3:45 p.m.

6

Q. Did you ever have occasion to
work as nursing supervisor on Ward 4A or 4B on the
night shift?

7

A. No.

8

Q. When you were working the then
eight-hour day as a nursing supervisor what were your
duties and responsibilities in general terms with
respect to Ward 4A/4B?

9

A. In general terms it was to
check on staffing to make sure that they had adequate
staffing, to check on the condition of certain
patients who might be listed on the tour end report,
and I made a nursing round at least once if not twice
a day.

10

11

12

13

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Q. When would be the first time
that you would physically be on Ward 4A/4B when you
were acting as a nursing supervisor?

A. As I came on duty I would pass



CC.5

1

2 through 4A/B before I went to nursing office.

3

4 Q. Where was the nursing office

5 located?

6

7 A. It was on the 4th floor but

8 in the Gerrard Street wing.

9

10 Q. That would place it then in

11 terms of time at approximately 7 or 7:15 in the

12 morning?

13

14 A. Yes.

15

16 Q. When would you next be on

17 Ward 4A/4B?

18

19 A. That was usually sometime

20 after nine. I would start my rounds on 4A/4B.

21

22 Q. When you worked as nursing

23 supervisor on the weekends were you normally

24 assigned responsibility only for Ward 4A/4B or did

25 you have in addition other wards to attend to?

17

18 A. I had 10 or 11 other wards to

19 attend to.

20

21 Q. You say you would start your

22 rounds on 4A/4B. Were those the first wards then on

23 which you did perform rounds when acting as nursing

24 supervisor?

25

A. Yes.

23

24 Q. And as a matter of general

25



CC. 6

1

2 practice would that tend to be approximately 9 o'clock
3 in the morning?

4 A. Or shortly after nine, yes.

5 Q. How long would those rounds
6 normally take?

7 A. Usually about 15 minutes.

8 Q. All right. Who would accompany
9 you on those rounds?

10 A. The nurses in charge of the wards,
11 the respective wards, would accompany me on rounds.

12 Q. As nursing supervisor would you
13 have had made available to you the tour end reports
14 for the patients on those two wards that day?

15 A. Yes.

16 Q. Apart from the rounds that you
17 did at approximately nine in the morning did you as
18 well do a second nursing round on 4A/B when you were
19 working as nursing supervisor?

20 A. I usually tried to. I would
21 make sure that I would see any children who were on
22 the tour end report.

23 Q. And if you did do a second round
24 would there be a standard time when you would normally
25 try to achieve that?

26 A. I used to start a round shortly
27 after two.



CC.7

1

2 Q. In the afternoon?

3

4 A. I would start my afternoon
rounds, yes.

5

6 Q. In addition to the conducting
7 of formal rounds on one or two occasions during that
8 eight-hour shift if there was an emergency of any
kind that arose on the ward would I be correct in
assuming that you would be on the ward then as well?

9

A. Yes.

10

11 Q. You would be summoned and you
would come to see what the emergency was?

12

A. Yes. I carried a beeper.

13

Q. All right.

14

15 But we know, Mrs. Radojewski, that
16 following the relocation of the Cardiology Unit to
17 Ward 4A and 4B at the beginning of April 1980 Ward 4A
18 had 12 infant beds and Ward 4B had 6.

19

20 As between the two wards in your
experience is it fair to suggest that 4A had physical
21 capacity for more infant patients and therefore from
time to time in fact housed more infant patients as
22 between those two wards?

23

A. Yes.

24

25 Q. Miss Costello has told us,
however, and this, sir, is found at Volume 93, page



CC.8

1

2 957, that there was not in her judgment nor her
3 experience a distinction drawn between the two wards,
4 in the sense of which ward would receive more gravely
5 ill patients.

6 In your experience, Ms. Radojewski,
7 was there a distinction drawn between the two wards
8 in that sense?

9 A. I was left with the impression
10 in that period of time that we had received some
11 iller infants, yes.

12 Q. Was that on a regular basis,
13 Ms. Radojewski, or was it at a particular time period
14 when you felt that had happened?

15 A. The time period from when the
16 ward opened, 4A opened, until after March, 1981.

17 Q. Are you saying then that
18 throughout the entire period from April 1980 until
19 after March of 1981 you had the impression, rightly
20 or wrongly, that Ward 4A was receiving sicker patients
21 than was Ward 4B?

22 A. Yes, I was left with that
23 impression.

24 Q. What was the basis for your
25 impression?

A. We seemed to be using more



CC.9

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equipment that we would need for children, infants, who were quite ill; we needed more monitors and more intravenous monitoring equipment. We seemed to be constantly shuffling beds to accommodate small infants in our room next to the nursing station. And I don't have any statistics with me but it is an impression I am left with, yes.

Q. We know, Mrs. Radojewski, that the capacity of Ward 4A to take more infants was confirmed by the fact that there were six more infant beds on that ward than 4B?

A. Yes.

Q. But I take it we can agree that merely because a patient was an infant did not necessarily place that patient in the gravely ill category?

A. That is right.

Q. So that there may at any given time be more infants on 4A but they may not be the most gravely ill patients on the two wards at that time; is that fair?

A. That is fair.

Q. And as between the two wards again are you suggesting that Ward 4A had a higher requirement for IV monitoring equipment than did Ward 4B?



CC.10

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A. It seemd that way at the time.

2

Q. Well, was there more on 4A than
4B?

3

A. We shared equipment.

4

Q. So that whatever IV monitoring
equipment there was available on the Cardiology Unit
was available mutually for both wards?

5

A. Yes.

6

Q. To the best of your knowledge
during that period of time, some 12 months, were there
any doctors or physicians who discussed with you
the assigning of the more gravely ill patients to
your ward as opposed to Ward 4B?

7

A. I find that - I get confused
when we had two cardiologists cover the wards. Can
you repeat that again for me, please?

8

Q. During that some 12-month
period of time did you have any discussions with
any of the staff cardiologists or other physicians
on the wards in which it was suggested that the more
gravely ill patients should be placed on Ward 4A
as opposed to Ward 4B?

9

A. No.

10

Q. Did you have any discussions
with Mary Costello about that matter?

11

12



CC.11

1

2 A. No, not that I can recall.

3 Q. I'm sorry?

4 A. Not that I recall.

5 Q. Do I take it then it was your
impression, given your exposure to the wards, that
6 Ward 4A had a great many sick patients?

7 A. I felt that, yes.

8 Q. As Head Nurse on Ward 4A would
9 you on all occasions when you were at work be
10 familiar with the patients on Ward 4B who were regarded
11 as being in critical condition?

12 A. Not necessarily all the time.

13 Q. Do I take it then that although
14 it would be preferable there might be occasions when
15 there could be gravely ill patients on Ward 4B
without your being aware of that fact?

16 A. There could be times, yes.

17 Q. As a normal matter, however,
18 when Mrs. Costello was on the eight-hour day shift
19 and you were on as well, did you communicate with
20 one another to brief each other, if you will, as to
which patients were gravely ill on both wards?

21 A. We may have at times, yes.

22 Q. Well, is it your recollection
23 that was a matter of practice between you as the two

24

25



CC.12

1

2 head nurses on that unit?

3

A. I don't recall for sure.

4

Q. I take it there would be times,
however, when you would be aware as to the identity
of the sicker patients on Ward 4B?

5

A. Yes.

6

Q. We have also heard from
Ms. Costello that the younger more gravely ill
patients on Ward 4B at least were generally assigned
to Room 431 on that ward even if that meant having to
move a patient out from that room to make room for
a new admission or a new patient being transferred in.

7

Was that true as well for Room 418

8

on Ward 4A?

9

A. Yes.

10

Q. All right. Were there particular
nurses that you as the Head Nurse on Ward 4A sought
to assign to Room 418 and the patients that were in
418 from time to time?

11

12

13

14

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25

A. Usually on the nursing team the
nurse that followed the team leader in the so-called
hierarchy was a very capable nurse and she was usually
assigned the sicker children.

Q. All right. Do I take from that
that in your view it was a desirable end to have very



CC.13

1

2 capable experienced nurses assigned to duties in that
3 room?

4 A. Definitely desirable.

5 Q. And when you as the Head Nurse
6 on 4A were assigning particular patients to particular
7 nurses, both for the day shift, the long night shift
8 and the evening shift, was it one of your objectives
9 to see to it that the more experienced nurses were
assigned to patients in that room?

10 A. Yes.

11 Q. To the best of your knowledge
12 was that practice followed on Ward 4B by Ms. Costello
13 as well?

14 A. I assume it was, yes.

15 Q. All right. We have heard,
16 Mrs. Radojewski, as perhaps you are aware, evidence
17 from a number of witnesses concerning medication
18 errors that occurred or may have occurred on Wards
19 4A/4B during the nine-month period of time from July
20 1980 through to the end of March 1981. And it has
21 been suggested by Ms. Costello, and this evidence,
22 sir, is found at Volume 93, page 1033, that if a
23 medication error occurred on either of those two
24 wards the person who made the error or the person
25 who detected the error, whichever it might be, would



CC.14

1

2 be required to complete and file an incident report
3 in respect of that error.

4 Was that the practice on Ward 4A?

5 A. Yes.

6 Q. And if an error had occurred
7 during the day shift when you were on duty is that
8 a matter which of necessity would be brought to your
attention as Head Nurse?

9 A. Yes.

10 Q. Would you be required to
11 participate in the completion of an incident report
12 or to at least review an incident report before it
13 had been completed by others?

14 A. I usually viewed the incident
15 report before it was completed.

16 Q. And if a medication error
17 occurred on Ward 4A during the long night shift or
18 during the evening shift is that a matter that would
19 be brought to your attention when you were next on
duty at the Hospital?

20 A. Yes, it was usually reported to
21 me during the morning report.

22 Q. Was it a requirement that you
23 be apprised of any such errors that had occurred
24 during the long night shift when you weren't there?

25



CC.15

1

2 A. I felt it was.

3

Q. Was that something you
4 communicated to your nurses on Ward 4A?

5

A. Yes.

6

Q. I take it then, Ms. Radojewski,
7 and please correct me if I am wrong, that if there
8 was an increase in the number of detected or known
9 medication errors on those two wards during that
10 nine-month period, that is something about which you
11 would have been made aware or personally observed?

12

A. Yes.

13

Q. To the best of your knowledge
14 during that nine-month period was there an increase
15 in detected or known medication errors occurring on
16 Wards 4A or 4B?

17

A. I believe there is a note to
18 some effect in either the communication book or the
19 ward meeting book, there is some concern.

20

Q. All right. Perhaps we can
21 deal with those.

22

The Commissioner has heard evidence
23 from other witnesses, Mrs. Radojewski, that in the
24 months of October and November, 1980, there were
25 four errors involving digoxin made: three in the
month of October and one in the month of November.



CC.16

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That was a situation where we have heard the correct dose of digoxin was given at 5:30 in the morning, but in error a second dose or at least the dose was repeated at 9:30 in the morning. Are those the errors that you are referring to?

A. Yes, they are.

Q. It is our understanding that none of those errors applied to the 36 children whose deaths are of concern to this Commission.

Are you as well aware of a medication error involving Brian Gage a patient on Ward 4A?

A. Not that I recall.

Q. Are you as well aware of a medication error involving a patient by the name of Paul Murphy who was a patient on Ward 4A?

A. I don't recall.

Q. To assist you with that, Ms. Radojewski, I am showing you an incident report with respect to Paul Murphy. I would ask you to confirm whether or not that is your signature on the bottom of the incident report?

A. Yes, it is.

Q. What was the date of the filing of that incident report?



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DM/PS

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A. The extended date is August
19th.

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Q. 1980?

5

A. 1980.

6

Q. And am I correct that Paul
Murphy appears to have received the wrong amount of
digoxin at 2100 hours on August 19th, 1980?

8

A. Yes.

9

Q. He in fact received too much,
there was an error in the calculation of the appropriate
dosage?

12

A. Yes.

13

Q. Mr. Registrar, could you show
the witness if you would, please, Exhibit 80C, which
is Volume 3 of the medical record of Paul Murphy.

15

THE COMMISSIONER: Is this to be an
exhibit?

17

MS. CRONK: Yes, please, sir, if you
would make that an exhibit.

19

THE COMMISSIONER: Yes, all right,

20

364.

21

---EXHIBIT NO. 364: Patient Incident Report re.

22

Paul Murphy, 19.08.80.

23

Q. I would ask you to turn first
if you would please, Ms. Radojewski, to page 15, and

24

25



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2 I am going to suggest to you that according to page
3 15 of the medical chart of the child he appears to have
4 been admitted to the hospital from the cardiology
5 clinic on August 19th, is that correct?

6 A. Yes.

7 Q. And he had been in and out of
8 hospital as I understand it for a number of years.

9 A. Yes.

10 Q. Can I ask you now if you would
11 to turn to page 124 of the chart, which is a
12 portion of the progress notes that were completed on
13 the child.

14 A. I am not sure if I have the
15 correct number. I can't read it.

16 Q. They are difficult to read, but
17 it is the top right hand corner and I direct your
18 attention to the nursing note which appears at the
19 top of that page, Ms. Radojewski. It would seem
20 on the basis of this note that the child was admitted
21 to Ward 4A before 5:00 in the morning again on
22 August 19th, would you agree with that?

23 A. Yes.

24 Q. If the digoxin error that appears
25 to have occurred with respect to the child at the time
on the incident report is correct, appears to have



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2 occurred at 9 p.m. on the evening, that is, at 2100
3 hours.

4

A. Yes.

5

6 Q. And I ask you to turn now if
7 you would please to page 142 of the chart, this
is a clinical chemistry computer printout, do you have
that?

8

A. Yes.

9

10 Q. There is a reading or a digoxin

level there of 1.8 nanograms, do you see that?

11

A. Yes.

12

13 Q. That appears to have been
14 recorded on August 19th, 1980 from a sample taken at
15 10:45 in the morning.

16

A. Yes.

17

18 Q. To the best of my knowledge, Ms. Radojewski, this is the only digoxin level recorded
19 on this child during his last admission at the Hospital
20 for Sick Children. Are you aware of any other?

21

A. I don't recall.

22

23 Q. It appears that this particular
24 level, or at least the sample on which the level was
25 ultimately obtained, was drawn at 10:45 in the
morning on August 19th, and later that evening at
approximately 9:00 there was a medication error



1

2 involving digoxin, the child seems to have received
3 too much, according to the calculations.

4 A. Yes.

5 Q. It would appear then that there
6 was no digoxin level taken after the happening of
7 that error, at least insofar as you are aware, is
8 that fair?

9 A. That's right.

10 Q. We know, however, that Paul
11 Murphy did not die Ms. Radojewski, until four days
12 later, that is August 23rd at approximately 10:30 in
13 the evening. Does that accord with your recollection
14 of the date and timing of that child's death?

15 A. Yes.

16 Q. And I would ask you to turn to page
17 140 of the chart if you have it still in front of
18 you, to the medication and treatment record of this
19 child. It appears that the child continued on
20 digoxin, a regime of digoxin therapy after the 19th
21 of August through until the morning of the 23rd of
22 August, am I reading those entries correctly?

23 A. Yes.

24 Q. It is also my understanding that
25 there was a "do not resuscitate" order in place with
respect to this child, does that accord with your



1

2 recollection?

3 A. Yes.

4 Q. Apart from the error involving
5 Paul Murphy and the one that I have suggested occurred
6 with respect to Brian Gage, of which you have no
7 recollection, are you aware of a medication error
8 having occurred involving Kristin Inwood, a patient
on Ward 4B?

9 A. I remember hearing the name on
10 4B, but I don't remember much other.

11 Q. Apart from those errors, that is,
12 the three that occurred in October, the one in
13 November involving the giving by error of a repeat
14 dose of digoxin, and the one involving Paul Murphy
15 that we have just looked at and the two I have sug-
16 gested to you, Brian Gage and Kristin Inwood, are you
17 aware of any other digoxin medication errors which
18 occurred during this nine month period on either
19 Wards 4A or 4B involving any of the 36 children
who are of concern to this commission?

20 A. I don't recall.

21 Q. One way or the other?

22 A. No.

23 Q. Do you have any recollection
24 today at all of any other medication error involving

25



dr. ex. (Cronk)

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6 2 digoxin having occurred with respect to any specific
3 child on those wards?

4 A. No, I don't recall them.

5 Q. Dealing with medication errors
6 generally on these 36 children, Ms. Radojewski, that
7 we are concerned with, it is my understanding that
8 apart from an error involving digoxin there was a
9 further medication error involving one of these 36,
10 that is an error involving Laurette Heyworth, do
11 you have a recollection with respect to that
error?

12 A. No, I don't.

13 Q. I am showing you another patient-
14 infant report with respect to Laurette Heyworth, and
15 once again it appears that the signature of the
16 supervisor on that incident report is yours, is that
correct?

17 A. Yes, it is my signature.

18 THE COMMISSIONER: 365.

19 MS. CRONK: Thank you, sir.

20 ---EXHIBIT NO. 365: Patient Incident Report Re.

21 Laurette Heyworth, 20.08.80.

22 Q. It appears, Ms. Radojewski, that
this error took place on August 20th, 1980?

23 A. Yes.

24

25



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Q. In this case the error involved not the drug digoxin, but rather the drug lasix?

4

A. Yes.

5

Q. And am I reading the incident report correctly if I suggest that in this case the error was caught in time, it was detected before the error had in fact been made and the situation was corrected?

9

A. Yes.

10

11

Q. So that the child in fact received the appropriate amount of lasix as had been ordered by the attending physician?

12

13

A. Yes.

14

15

16

17

18

19

Q. That appears to have been an error, as I have suggested, with respect to one of those 36 children involving medication error but not digoxin. Does this incident report help you in any way to recall any other medication errors involving either digoxin or any other drug with respect to any of these 36 children on the ward?

20

A. I am sorry, I just can't remember.

21

Q. That is helpful. Thank you.

22

23

24

25

Apart from the errors that we have looked at, and those that I have drawn to your attention, Ms. Radojewski, were you at any time during this nine month period under



1

8 2 the impression, or did you have the impression that
9 3 there had been an increase in medication errors on
10 4 either Wards 4A or 4B, apart from the ones that we
11 5 have spoken about?

6

A. No, I don't recall that there
was.

7

8 Q. For your benefit, sir, and to
9 assist the witness, I have asked counsel for the
10 hospital to produce to us the records of the medica-
11 tion errors known to have occurred on Wards 4A/4B
12 during this nine month period. I am producing a letter
13 addressed to the Commission from Mary Thomson of
14 Messrs. Dowling and Henderson to which is attached
15 a schedule -- I'm sorry, sir, that is dated January
16 11th, 1984, to which is attached a schedule or list of
17 the known medication errors which occurred on these
18 two wards during this nine month period of time. It
19 includes, for example, the medication error involving
20 Paul Murphy, as reflected by the incident report that
21 Ms. Radojewski has identified; and the error involving
22 Laurette Heyworth on August 28th and the incident
23 report that has just been filed.

24

25

I draw your attention, sir, to the
last paragraph on the first page of the letter in
which Ms. Thomson confirms that on the basis of the



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2 information available to counsel for the hospital
3 with the exception of the error involving Paul
4 Murphy, the error involving Laurette Heyworth and
5 those about which the Commission had already heard,
6 that is, Kristin Inwood and Brian Gage, none of the
7 medication errors which occurred on Wards 4A/4B as
8 listed in the schedule involved the 36 children
9 about which this commission is concerned, sir.

10 MS. CRONK: That is really for
11 your edification and assistance, I know you can't
12 help me with the contents of that letter. I would
13 ask, sir, that under those conditions the letter
14 be marked as the next exhibit.

15 THE COMMISSIONER: Yes, all right.
16 Exhibit 366.

17 ----EXHIBIT NO. 366: Letter to the Commission from
18 Dowling and Henderson, January
19 11th, 1984 with attachment.

20 Q. Ms. Radojewski, during that
21 nine month period of time, again that is July, 1980
22 through to the end of March, 1981, was there ever
23 an occasion which you can now recall when a member
24 of the nursing or the medical staff on either ward
25 suggested to you that a medication error had occurred
involving a patient on Ward 4A/4B in circumstances



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10 2 where an incident report had not been filed, was that
3 ever suggested?

4 A. Not that I can remember.

5 Q. Would it be fair of me to suggest
6 if that kind of a situation had been drawn to your
7 attention, Ms. Radojewski, steps would have been taken
8 to report the matter and to investigate it further?

9 A. Yes.

10 Q. And I take it you have no recol-
11 lection of that kind of an incident having occurred?

12 A. I don't recall.

13 Q. And similarly, looking back now
14 as you sit here today, over that nine month period,
15 do you have the impression that there was during that
16 nine month period an unusually high number, or a
17 higher number than normal of medication errors on
18 those wards? I am just asking for your own recollec-
19 tion, Ms. Radojewski, in looking back on those nine
20 months when you were head nurse on Ward 4A, do you
21 have the impression that there was an incidence
22 of medication errors higher than normal on those
23 wards?

24 A. No, I am not left with the
25 impression that there was one higher than normal.

Q. In the normal course of events



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11 2 if those kinds of errors were occurring with any
2 degree of frequency, I think you have told us that
3 you would have expected they would have been brought
4 to your attention whether they occurred during the day,
5 or during the night when you were not there.
6

7 A. Yes.
8

9 Q. Thank you. You have told us
10 that you worked normally the eight hour day shift
11 on Ward 4A except for those weekends when once every
12 two months you came in to work as nursing supervisor.
13 If an arrest and a death occurred on either 4A or
14 4B during the day, is that something that of necessity
15 you would be aware of?
16

17 A. Yes, I believe I would be aware
18 of it.
19

20 Q. That would be true even if the
21 arrest and the death, if it had resulted in death,
22 had occurred on 4B?
23

24 A. If it was during the day?
25

19 Q. Yes.
20

21 A. Yes.
22

23 Q. And similarly if an arrest and
24 a death occurred at night on Ward 4A or 4B, is that
25 something that necessarily would be brought to your
attention when you were next on duty in the ward?
26



12

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2 A. Not necessarily 4B.

3

Q. Let's deal then simply with 4A.

4

Would you necessarily expect that an arrest and
death that had occurred during the night would be
brought to your attention?

5

6 A. Yes, certainly.

7

8 Q. In the normal course of events
9 would it be your expectation that the members of the
10 nursing staff on 4B, or alternatively your colleague
11 Mrs. Costello, would alert you to the fact that there
12 had been a death on 4B?

13

A. Yes.

14

Q. We have heard in evidence from
15 a great many witnesses, Ms. Radojewski, that in this
16 nine month period with which we are concerned, and
17 commencing specifically on June 30th, 1980, there
18 was an increase in the number of arrests and deaths
19 which did occur on Wards 4A/4B. As I understand it
you are aware of the identify of those 36 children
who died on those wards, do I have that correctly?

20

A. Yes.

21

Q. And in some instances, as I
22 understand it, you were personally familiar with the
23 condition of the patient and the course of their
medical care?

24

25



13

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A. Yes.

3 Q. In other instances as I understand
4 it you do not have any recollection either of the child
5 or of the circumstances of their death, am I summarizing
6 it correctly?

7

A. Yes.

8 Q. I am showing to you now, Ms.
9 Radojewski, a list that has been prepared by Commission
10 staff, a copy of which I provided to you through your
11 counsel at an earlier date, of selected children about
12 whom as I understand it you do have some recollection,
13 either as a patient or the circumstances surrounding
14 their death, is that correct?

15

A. Yes.

16

Q. And as well, the date of the
17 particular child's death is listed; and the time of
18 their death; the ward upon which they died; and
19 on the right hand side of the page the day and
20 hours that you worked at the hospital in association
21 with the day of death. Do the entries in the day and
22 hour of duty column accurately set out the days when
23 you worked in association with the date of death of
24 these children?

25

A. Yes.



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2 Q. I draw your attention parti-
3 cularly to Item No. 6 - excuse me, and I will return
4 to this, but that is Kelly Monteith. You are listed
5 as having worked on August 18th for an 8-hour day
6 and on August 19th for an 8-hour day.

7 Mr. Registrar, could you show the
8 witness if you would please Exhibit 335 which are the
9 WIN sheets for Ward 4A.

10 Could I ask you, Mrs. Radojewski,
11 if you would please to take a look at the hours of
12 duty for August 18th.

13 THE COMMISSIONER: Should we make this
14 an exhibit?

15 MS. CRONK: I'm sorry, sir, yes.

16 THE COMMISSIONER: 367.

17 ---- EXHIBIT NO. 367: Document entitled "Elizabeth
18 Radojewski - (List of
19 Relevant Children)"

20 MS. CRONK: Q. Do you have the
21 entries for August 18th?

22 A. Yes, I do.

23 Q. And it is my understanding
24 that you worked an 8-hour day shift on that day and
25 that appears to be reflected by the WIN sheet, is that
correct?

A. I actually worked a long day



1

EE2 2 on Monday, August 18th.

3

Q. That's a 12-hour day?

4

A. Yes.

5

Q. Is that reflected anywhere on
the WIN sheet for August 18th?

6

A. I believe this copy is difficult to see, but the notation, the copy in reviewing the WIN sheets that I saw, it was much clearer that there was "long day" written in the adjustment column.

11

Q. So, you are interpreting the entry in the adjustment column as being the "LD", long day?

13

A. Yes.

14

Q. Quite apart from what --

15

THE COMMISSIONER: I'm sorry, where will I find that?

17

MS. CRONK: I'm sorry, sir, under August 18th.

19

THE COMMISSIONER: Yes.

20

MS. CRONK: Beside the name of Mrs. Radojewski, which is the first that appears at the top of the page.

22

THE COMMISSIONER: Oh, yes, yes, I see, all right.

23

25



EE3

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2 MS. CRONK: Q. Apart, Mrs. Radojewski,

3

4 from what is listed on the WIN sheets do you have a
5 personal recollection of having worked a 12-hour day
6 shift on August 18th?

7

8 A. I remember that occasionally
9 I would work a 12-hour day if our team leader was ill
10 and there was no replacement for her.

11

12 Q. Do you have any reason other
13 than what appears in the WIN sheets to think that
14 you did so on that day, August 18th?

15

16 A. I remember that I did one in
17 the summer because that entitles me to some time off
18 during the week, which is unusual.

19

Q. It could have been that day?

20

A. Yes.

21

22 Q. Mrs. Radojewski, apart from
23 that mystery, if you will, could we turn please to
24 the first child who is listed on Exhibit 367. That
25 child is Alan Perreault. You were on duty on July
8th, the day of his death, as I understand it.

26

A. Yes.

27

28 Q. He died, according to the
29 information in evidence before the Commission, at
30 1:45 p.m. in the afternoon on July 8th when you were
31 working an 8-hour day shift.

32

33



EE4

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2 Mr. Registrar, could I ask you to
3 provide to the witness please Exhibit 360, it is the
4 Tour End Reports.

5 It is my understanding that copies of
6 the Tour End Reports have now been made available to
7 all other counsel.

8 Mrs. Radojewski, I'm sorry, could I
9 ask you to turn please to page 6. As I understand
10 it, at page 6 we see the Tour End Report for Alan
11 Perreault on July 7th, that is the day before he
12 died. I would ask you to look to the entry for the
13 8-hour day shift which appears on the left-hand side
14 of the page. Can you identify the handwriting for me?

15 A. The entry concerning Alan
16 Perreault?

17 Q. Yes.

18 A. It looks like Mrs. Croswell's
19 writing.

20 Q. You don't recall having made
21 that entry yourself?

22 A. No, that's not my writing.

23 Q. Am I correct in summarizing
24 the entry on July 7th, the day before his death, as
25 indicating that the child's condition was deteriorating,
he was in fact in a poor condition?



EE5

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A. Yes.

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All right. And the Tour
End Report as well -- well, I'm sorry, as I under-
stand it, perhaps you can simply confirm this for me,
there was a "do not resuscitate" order in place with
this child.

A. That was my understanding.

Q. Could I ask you to turn now
if you would please to the next page, page 7 of the
Tour End Report and again look at the entries for the
8-hour day shift on July 8th. This is the day of
his death. Is that your handwriting?

A. Yes.

Q. And that records the fact
of his death and the fact further that no resuscita-
tion was undertaken?

A. Yes.

Q. Were you physically present
for his death at the time of his arrest, to the best
of your recollection?

A. I remember seeing his mother
holding Alan beside his Isolette.

Q. Do you recall, Mrs. Radojewski,
when you reported for work on the day he died what the
nature of his condition was, according both to the



1
EE6 2 report that you received that morning and according
3 to the Tour End Report that you have just looked at?

4 A. I don't recall the report
5 I got that morning.

6 Q. Do you recall whether or not
7 he was expected to die that day? Was he in the
8 process of dying when you attended for work on July
8th?

9 A. I don't recall.

10 Q. Did you have any discussion
11 concerning his death with any of the nursing staff
12 on either Ward 4A or 4B during which it was suggested
13 that the cause of his death was uncertain or a matter
14 of puzzlement to the nurses who had been present?

15 A. I don't remember any discussion
16 about Alan Perreault.

17 Q. Do you recall any discussion,
18 and by that I take it you mean that you do not recall
19 any discussion concerning the cause of his death or
20 any certainty or uncertainty that may have attached
21 to it?

22 A. Yes, that's right.

23 Q. Do you recall any discussion
24 with anyone, be it a representative of the medical
25 staff or the nursing staff on those wards, as to the



1

EE7 2 timing of his death?

3

A. No, I don't recall any dis-
cussion.

5

Q. Was it ever suggested to you
at any time by any one, again be it a person from the
medical or nursing sides of the staff in the Hospital,
that there may have been some involvement of digoxin
in his death?

9

A. No, I don't recall that.

10

Q. With respect to the entries
which appear in the Tour End Reports, and we have
had this in part from other witnesses, Mrs. Radojewski,
and I would simply like to obtain your understanding
of it, it is my information that a particular child
might be listed on the Tour End Report in the first
instance if the child's condition was considered very
serious or if he or she were gravely ill; is that
correct?

18

A. Yes.

19

Q. And in addition to that, if
a patient was a new admission or a new transfer on to
Wards 4A/4B, in those circumstances would you expect
to see the patient's name and a description of his
condition in the Tour End Report?

23

A. Yes, I would.

24

25



EE8

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Q. And if surgery was scheduled or some operative procedure for the patient, would you expect to see once again the name of the patient on the Tour End Report?

6

A. Yes, usually it was.

7

Q. Are there any other situations which you can now recall in which there would be an inclusion on the Tour End Report for a particular patient other than those three kinds of situations that I have just described?

11

12

13

A. If there was constant nursing care or shared nursing care, usually those children were listed on the Tour End Report.

14

15

16

17

Q. Was there any other situation which would normally require the entry of some kind of a remark about the child on the Tour End Report?

A. Did you say when the child had expired?

18

19

Q. No. If the child died, there would be an entry in the Tour End Report?

20

A. Usually there would, yes.

21

Q. Any other situation that you can now think of?

22

23

A. I can't recall any others at this moment.

24

25



1
2 EE9 Q. All right. When you came on
3 during the normal course of your hours of duty for
4 an 8-hour day shift, would you have available to you
5 the Tour End Report from the previous shift?

6 A. No.

7 Q. All right. When would you,
8 during the course of an average day, see the Tour End
9 Report for the previous shift?

10 A. I didn't see them.

11 Q. All right. Did you have any
12 involvement in the completion of the Tour End Reports
13 for the days when you were on duty?

14 A. Yes, I did. The initial
15 part of it was started by the night nurse, meaning
16 that she did the parts where it says the nurse in
17 charge and I filled it in, what I could, for my day
18 shift and sent it to the nursing office by, usually
19 three o'clock.

20

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Q. All right. I take it then
that on every day when you were in the Hospital you
would have some involvement in the completion of the
tour end report for your eight-hour day shift?

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A. Yes, except when I was
Nursing Supervisor.

Q. On the weekends?

A. Yes.

Q. Could we turn then please to
the next child, that is, Andrew Bilodeau. He died
on July 22nd, 1980, according to our information at
approximately 2 o'clock in the morning on Ward 4A.
He had been admitted on July 19th, 1980, which was
a Saturday, Mrs. Radojewski, to assist you. It is
my understanding that that was not one of the weekends
when you were working as a nursing supervisor on
Ward 4A/4B, is that correct?

A. Yes, that's correct.

Q. Did you in fact see this child
on the day of his last admission to the Hospital?

A. Can you repeat that for me?

Q. Did you in fact see this child
on the day of his last admission to the Hospital, that
is, July 19th, which was a Saturday?

A. No, I didn't see him on that day.

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Q. As I understand it however

you did work on Monday, July 21st, the day before the child died. Do you recall seeing him on that Monday?

A. Yes.

Q. All right. What was the nature of the condition when you saw him that morning?

A. I recall him as looking fairly ill to me. He was in a small, what we call a stork bed in a corner in Room 418. I'm a little bit confused if that's how he was early in the morning but that's how I remember him when I left that day. As I recall, they had him at the head of a bed elevated in a sling, what we call a cardiac sling. I'm quite sure I remember oxygen.

Q. Do you recall anything else about his condition when you left work that day?

A. He had an echocardiogram done in the afternoon which confirmed the diagnosis. I remember he looked quite ill to me as I was leaving that day.

Q. You have told me, Mrs.

Radojewski, that you remember seeing the child in a cardiac sling. Can you explain for us what that is?

A. It's not really a device, we just take a piece of linen and usually with these



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very small infants, we use a very long diaper, attach it to the top of the bed with pins and sit the child on it. So, essentially the child is propped up in bed with the head of the bed elevated, otherwise, infants would slide right down to the bottom of the bed.

Q. All right. Is it a method then really of ensuring that an infant is elevated in a sleeping posture while they're in the bed?

A. Yes. They don't always sleep, but yes.

Q. You have told us I take it that it wouldn't be unusual to see infants on that ward in that position?

A. It's unusual to see them lying down.

Q. Was this child lying down in the cardiac sling?

A. No.

Q. So, this was in fact the norm, that they be in a cardiac sling?

A. Yes.

Q. There is nothing unusual about that feature?

A. No.



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Q. Right. And you have also

told us that the child as best as you can recall it
may have been in oxygen when you last saw him the
day before he died?

A. Yes.

6

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Q. And having regard to what we
know were the difficulties that many of these children
had while they were on the cardiology unit, I take it
that that too would not be unusual to see a child in
oxygen?

11

A. No, it's not unusual.

12

13

Q. Was there anything unusual in
the fact that he had an echocardiogram performed that
afternoon?

14

15

16

17

A. It was my feeling, I remember
Andrew Bilodeau for that reason I had felt that he
should have had his echocardiogram very soon after
his admission and not waited over the weekend.

18

19

20

21

Q. Well, we know that he was
admitted on the 19th, which was the Friday, July 19th.
Are you saying then when you came into work on the
Monday the echocardiogram had not been done but it
was in fact carried out that day?

22

A. Yes.

23

24

Q. All right. When you left work

25



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2 that day as best as you can now recall it was
3 Andrew Bilodeau considered to be at imminent risk
4 of death?

5 A. Not that I recall.

6 Q. Was his condition critical at
7 that time in your judgment?

8 A. No.

9 Q. Could I ask you if you still
10 have the tour end reports there, to turn if you would
11 please to page 8. This is the tour end report,
12 Mrs. Radojewski, for July 19th, the day of his
13 admission. I take it he would be automatically
14 listed on the tour end report from what you have told
15 us on that day simply because he was in fact a new
16 admission to the ward on the 19th?

17 A. Yes, he was transferred from
18 another hospital.

19 Q. And if you would take a look
20 at page 9 then if you would, these are the entries
21 for July 21st before he died. If we look at the
22 face side, or the front side of that page, we know
23 that you worked that day. I don't see any mention
24 of Andrew Bilodeau. Do I correctly infer from that
25 as you have suggested that when you left work at the
end of your eight hours of duty you did not consider



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(Cronk)

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his condition critical and did not list him as
seriously ill on the tour end report at that point;
page 9, on the front.

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2 MR. ROLAND: I think it is on the
3 back side. The reason it is on the back side is that
4 you can't get all the babies on the front side so
5 it slides over the back side.

6 MS. CRONK: That is helpful. I am
7 grateful to my friend.

8 Q. Was the entry then on the
9 back of page 9 made during your 8-hour day shift
on the 21st of July?

10 A. Yes, it was.

11 Q. That records as well later in
12 the day the death, the fact of his death at 1:45 in
13 the afternoon although the time isn't mentioned?

14 I'm sorry, it records your assessment
15 of his condition when you left that day. Do I have
16 that much correctly?

17 A. Yes.

18 Q. And then later after you had
19 left it records the fact of his death during the long
night shift? On the right-hand side of the page?

20 A. Yes. It is difficult to read.

21 Q. Is there anything in the
22 condition which is described on the back of the Tour
23 End Report for July 21st other than the fact of his
24 death which suggests to you that the child's condition

25



1
2 FF2 deteriorated in a significant fashion after you
3 left work?

4 A. The fact that he had been
5 given his -- you mean the other night entries?

6 Q. Yes.

7 A. The complete 24 hours?

8 Q. Yes.

9 A. The fact that he was given
10 his digoxin intravenously and another dose of Lasix
11 indicates that he may have deteriorated somewhat, yes.

12 Q. When you learned of his
13 death, Mrs. Radojewski, having regard to the fact when
14 you had left the day prior you did not regard his
15 condition as being critical, you did not regard him
16 as being at imminent risk of death, were you sur-
17 prised by his death and did you regard it as unexpected?

18 A. I remember being somewhat
19 surprised, yes.

20 Q. Were you concerned as to what
21 had caused his death?

22 A. I was informed of his
23 diagnosis and I know that from the experience I had
24 children with that diagnosis are at risk.

25 Q. Are you referring now to the
results of the Echo cardiogram?



Radiojweski
dr.ex. (Cronk)

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FF3 2

A. Yes.

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Q. Were they known to you when

you left the day prior at the end of your shift?

5

6

7

A. I don't recall. I know that he had it done late in the afternoon, but I can recall that I remember his diagnosis but I am not sure when I learned of it.

8

9

Q. All right. What feature of

his diagnosis are you referring to?

10

A. The truncus arteriosis.

11

12

13

Q. When you learned what the

results of the Echo cardiogram had been and that was his diagnosis, did that serve to reassure you in any way as to why the child had died?

14

15

A. It was explainable to me, yes, by his diagnosis.

16

17

18

19

20

21

Q. During the course of the day

when you were at work having learned of his death,

did you have any discussion with any members of the

nursing staff, be they from 4A or 4B, during which

it was suggested that there was some degree of un-

certainty in their minds as to why the child had died?

22

A. Not that I recall.

23

Q. Do you recall having any

discussion with any of the physicians associated with

24

25



Radojewski
dr.ex. (#Cronk)

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the Cardiology Unit in which doubt of any kind was
expressed as to why the child had died?

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A. In the communications book
or the ward meeting book, I am not sure which one,
I had made a note that I had talked to Dr. Contreras,
and Andrew Bilodeau I believe was one of the ones I
had talked about.

8

9

MS. CRONK: Mr. Registrar, could you
show the witness, if you would please, Exhibit 300.

10

11

Q. If I could refer you to
the first tab, Mrs. Radojewski --

12

A. Yes.

13

Q. -- the entry at page 5 for
July 31, 1980, do you have that?

14

A. Yes.

15

16

Q. Is that the note to which you
are referring?

17

A. Yes.

18

19

Q. And is that your note for
July 31st?

20

A. Yes, it is.

21

22

Q. Can you help me, please, as
to how you now recall you spoke with Dr. Contreras
about this child?

23

24

A. In reviewing the communications

25



1
2 FF5 book I made a note in the column that I had talked
3 with Carlos, and that is Dr. Carlos Contreras.

4 Q. You are referring to the
5 handwritten notation on the left-hand side of the
6 page?
7

8 A. Yes.
9

10 Q. We will come to the matter of
11 Amber Dawson and Lillian Hoos in due course, but do
12 you recall now, Mrs. Radojewski, having a specific
13 discussion with Dr. Contreras concerning the deaths
14 of those three children?
15

16 A. I don't recall it other than
17 it being written in this book.
18

19 Q. Do you recall what Dr.
20 Contreras said during that discussion with respect to
21 the cause of death of Andrew Bilodeau, if anything?
22

23 A. Other than what is written in
24 this book I don't recall.
25

26 Q. Do you know when --
27

28 THE COMMISSIONER: Where is the
29 reference to Dr. Contreras? Where do you find that?
30 Or is there --
31

32 MS. CRONK: Yes, sir. On the left-
33 hand side of the page in handwriting it says "Talked
34 to Carlos", on the left-hand side of the page.
35

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Radojewski
dr.ex. (Cronk)

FF6

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2 THE COMMISSIONER: Oh, yes, I see.

3

4 MS. CRONK: Q. And I take it that
is Dr. Contreras' first name?

5

A. Yes.

6

7 Q. Do you recall speaking to
Dr. Contreras on July 31st or were you recording a
conversation that had occurred earlier?

8

9 A. I usually record the conversa-
10 tions as I had them, so I am sure I recorded the
11 conversation I had on July 31st on the 31st.

12

13 Q. Did you have any particular
14 reason for raising with Dr. Contreras the death of
15 Andrew Bilodeau?

16

17 A. It may have been a concern
18 that I had or, in looking back, it may have been a
19 concern that was raised.

20

21 Q. Do you recall what your con-
cern was?

22

A. No, I don't.

23

24 Q. During the course of that
25 discussion with Dr. Contreras was it suggested by --
I'm sorry, who was there other than yourself and
Dr. Contreras?

26

27 A. I don't recall. I believe
28 it was just the two of us.

29

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FF7

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2 Q. Was it suggested to you at
3 any time, be it by Dr. Contreras, any other physician
4 or any member of the nursing staff, that there might
5 have been some involvement of a drug in contributing to
6 or causing this child's death?

7 A. There was no discussion.

10

8 Q. Was it ever suggested to you
9 by anyone that there might have been a drug that
either contributed to or caused this child's death
10 as best as you can now recall?

11

A. No.

12

13 Q. As best as you can recall
14 was that matter raised at all during your discussion
with Dr. Contreras?

15

A. No.

16

17 Q. Did you discuss this child's
death with any other physician associated with the
Cardiology Unit other than Dr. Contreras?

18

A. No, I didn't.

19

MS. CRONK: All right.

20

21 Sir, I am about to move to another
topic.

22

23 THE COMMISSIONER: All right. Until
ten o'clock tomorrow morning then.

24

25 --- whereupon the hearing was adjourned at 4:30 p.m.
until Tuesday, the 28th day of February 1984, at
10:00 a.m.

